Benefits Choices 2009

OPEN ENROLLMENT

Retirees
Surviving Spouses
LTD Terminees

Annual Open Enrollment
October 20 - November 10, 2008

Health Benefits Employee Services
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Health Benefits Employee Services
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2009 Benefits Choices ANNUAL OPEN ENROLLMENT

October 2008

Dear Sandia Retiree, Surviving Spouse or Long-Term Disability Terminee,

Sandia National Laboratories is conducting our annual Open Enrollment for Health Plan Choices for 2009. Refer to this booklet and your packet to get important information on the options and changes for the next year.

IMPORTANT: IF YOU HAVE NO CHANGES, THERE IS NO ACTION NECESSARY.

If you need or want to change your health plan(s) or that of your dependents that are covered by medical or dental, please complete the change form located in this booklet. If you have questions about your benefits, submit your question via email to http://hbe.sandia.gov. If you do not use email, in Albuquerque, call (505) 844-HBES (4237). If you are located outside of Albuquerque, call (800) 417-2634, and then dial 844-4237. Please leave a detailed message. A Benefits representative will call you back as quickly as possible.

2009 Changes - High Level Overview

- Elimination of the CIGNA Premier PPO, CIGNA Senior Premier PPO, and UnitedHealthcare High Deductible Health Plan medical plan options.
- Plan design changes (e.g., copays and coinsurance), as described under each plan section.
- CIGNA In-Network Pharmacy Plan will no longer be managed by CIGNA. The Pharmacy benefit manager will be Catalyst Rx.
- Retirees no longer have the option to waive Prescription Drug coverage.
- New Dental Care Plan replaces the Dental Expense Plan (Retirees Only) - Employees who retire after December 31, 2008 will pay a premium for this plan.
- Sandia will no longer offer **new** Class II dependent enrollments. Current Class II dependents will be grandfathered.
- Class I eligibility rules have been modified. Please review the Eligibility section in this booklet if you have Class I dependents enrolled.

To insure you understand the changes, we recommend you carefully review all the information in this booklet and review the Medical Plans Comparison Chart included in this package. You may also visit our web site at http://oe.sandia.gov for more information.

Sandia Benefits Department

Welcome to Open Enrollment Benefits Choices 2009

It is time again to make your benefits decisions for the coming year. This booklet is designed to offer a brief look at each of the plans available during Open Enrollment. There are a number of important changes to the health plans offered in 2009. We recommend you carefully review all the information in this booklet and the Medical Plans Comparison Chart included in this package.

Sandia's Open Enrollment period for Benefits Choices 2009 will run from October 20 to November 10, 2008.

All enrollment changes (including to add/drop a dependent) require completion of the Open Enrollment Change Form included in this book. The Open Enrollment Change Form must be postmarked on or before November 10, 2008. All benefit changes take effect January 1, 2009, for the 2009 calendar year.

Summaries in this booklet are condensed information pieces and do not replace or modify the Summary Plan Descriptions for the plans.

2009 Medical Plan Options Change
Effective January 1, 2009, the CIGNA Premier and CIGNA Senior Premier PPO Plans, and UnitedHealthcare High Deductible Health Plan are no longer offered as retiree medical plan options.

All retirees enrolled in one of these plans must select a new medical plan during Open Enrollment.

Important

- All changes must be mailed and postmarked by **November 10, 2008** or they will not be accepted.
- If you have no changes, you do not need to complete the Open Enrollment Change Form.

Do you need to complete an Open Enrollment Change Form?

	Take Action	No Action
Medical Coverage	• To enroll in a new medical plan if you are currently in the **CIGNA Premier, CIGNA Senior Premier PPO Plan, or UHC High Deductible Health Plan** • To enroll if not currently enrolled • To change your current medical plan • To add or disenroll a dependent • To waive coverage	No change in your current medical coverage
Dental Coverage	• To enroll if not currently enrolled • To add or disenroll a dependent • To waive coverage	If you want to be enrolled in the new Dental Care Plan

UNITEDHEALTHCARE (UHC) PREMIER PREFERRED PROVIDER ORGANIZATION (PPO) PLAN

The UnitedHealthcare (UHC) Premier PPO Plan is administered by UnitedHealthcare. This PPO Plan allows members to see any licensed provider, although benefits are greater when care is received from a UHC network provider.

UnitedHealthcare Premier PPO Plan Key Points

Eligibility:

This plan is available to non-Medicare primary retirees, survivors, LTD terminees and their non-Medicare primary Class I and Class II dependents. See "Eligibility Guidelines for Retirees" section for 2009 changes.

> **Note**: If your dependent is Medicare primary and you enroll in this Plan, you can only enroll your dependent in the UHC Senior Premier PPO Plan. Class II dependents who are Medicare-primary will be enrolled in the UHC Senior Premier PPO Plan.

Plan Changes Effective January 1, 2009:

- Office Visit Copay – Primary Care Physician from $15 to $20 copay (in-network)
- Office Visit Copay – Specialist from $25 to $35 copay (in-network)
- Allergy Treatment from $25 copay to 15% of negotiated fees (in-network)
- Chiropractic – from combined Acupuncture/ Chiropractic benefit to a separate calendar year $1,000 maximum combined in- and out-of-network
- Acupuncture – from combined Acupuncture/ Chiropractic benefit to a separate calendar year $1,000 maximum combined in- and out-of-network
- Hypnotherapy and biofeedback are no longer covered
- Medical expenses incurred internationally will only be covered in-network for emergency care. Other eligible services will be covered under the out-of-network benefit.
- Prescription Drug – See Prescription Drug Coverage for UHC Premier PPO Plan, UHC Senior PPO Plan and CIGNA In-Network Plan changes

> **Note**: Due to the above copay changes, new white UHC ID cards will be issued to non-Medicare plan participants only. Watch the mail for your new ID card to arrive in January.

Guidelines:

- The prescription drug program is administered through Catalyst Rx. See Prescription Drug Coverage for UHC Premier PPO Plan, UHC Senior Premier PPO Plan and CIGNA In-Network Plan.
- Prior notification to UHC is required for certain medical services, procedures, and hospitalizations.
- Members are responsible for the first $300 of covered charges for failure to follow notification and/or precertification procedures.

- Certain in-network preventive care is covered at 100% before the deductible is met. It is solely up to the provider as to whether the service is coded as "preventive" or "diagnostic". Neither Sandia nor UHC 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.
- This plan provides in- and out-of-network benefits.
- Coverage is available worldwide for emergency and urgent care.
- Prescription drug copays and out-of-network behavioral health benefits do not apply to the out-of-pocket maximums.
- Prescription drug copays do not apply to the deductibles.
- Behavioral health benefits are provided through the OptumHealth Behavioral Solutions network of providers. Precertification to OptumHealth Behavioral Solutions is required before you receive certain behavioral health services.

Member Resources:

UnitedHealthcare Member Service
(877) 835-9855
Access to UHC member services 24 hours a day, seven days a week

OptumHealth Behavioral Solutions
(866) 828-6049
Access to OptumHealth Behavioral Solutions member services

Optum NurseLine (800) 563-0416
Provides access to a 24-hour nurse advice line

Care Coordination
Gives you personal support and easy access to information that will help you manage your health or condition, and make smart choices for the future. Contact UHC member services to find out more about this program.

Personal Health Support and Disease Management
Management programs for chronic conditions, complex health care needs and assistance with treatment decisions with comprehensive programs for coronary artery disease, diabetes, heart failure, and asthma. Contact UHC member services to find out more about these programs.

Comprehensive Website www.myuhc.com
Provides access to health information, to print Explanation of Benefits (EOB) online, order a new or replacement ID card or print a temporary ID card; personal health assessments and more.

UnitedHealth Allies (800) 860-8773
Save 10 to 50 percent on many health care products and services not paid for by your plan. Visit www.unitedhealthallies.com to learn more.

Selecting a Network Provider:

For a listing of in-network providers, you can go to the online Provider directory at www.myuhc.com. The username and password is SNL.

Additional Information:

For additional information on this Plan, refer to the UnitedHealthcare Premier PPO Summary Plan Description at http://www.sandia.gov/benefits/spd/pdfs/UHCPremierOpt-4-27-06.pdf, and the Retiree Medical Plans Comparison Chart.

UNITEDHEALTHCARE (UHC) SENIOR PREMIER PREFERRED PROVIDER ORGANIZATION (PPO) PLAN

The UnitedHealthcare (UHC) Senior Premier PPO Plan is administered by UnitedHealthcare. This PPO allows members to see any licensed provider in- or out-of-network.

UnitedHealthcare Senior Premier PPO Key Points

Eligibility:

This Plan is available to Medicare-primary retirees, survivors, LTD terminees and their Medicare-primary Class I and Class II dependents. See "Eligibility Guidelines for Retirees" section for 2009 changes.

> **Note**: If your Class I or II dependent is non-Medicare-primary and you enroll in this Plan, you can enroll your dependent in the UHC Premier PPO Plan.

Plan Changes Effective January 1, 2009:

- Chiropractic – from combined Acupuncture/ Chiropractic benefit to a separate calendar year $1,000 maximum combined in- and out-of-network
- Acupuncture – from combined Acupuncture/ Chiropractic benefit to a separate calendar year $1,000 maximum combined in- and out-of-network
- Hypnotherapy and biofeedback are no longer covered
- Prescription Drug – See Prescription Drug Coverage for UHC Premier PPO Plan, UHC Senior Premier Plan and CIGNA In-Network Plan changes.

Guidelines:

- The prescription drug program is administered through Catalyst Rx. See Prescription Drug Coverage for UHC Premier PPO Plan, UHC Senior Premier PPO Plan and CIGNA In-Network Plan.
- Members in the UHC Senior PPO Plan will be considered as having both Medicare Part A and Part B coverage for purposes of coordinating with Medicare and processing claims.
- Certain in-network preventive care is covered at 100%. It is solely up to the provider as to whether the service is coded as "preventive" or "diagnostic." Neither Sandia nor UHC 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.
- After the covered member has reached the $1,000 out-of-pocket maximum (not applicable to outpatient prescription drugs or out-of-network behavioral health benefits), benefits will be coordinated with Medicare.
- Provides in- and out-of-network benefits
- Coverage is available worldwide for emergency and urgent care.
- Prescription drug copays and out-of-network behavioral health benefits do not apply to the out-of-pocket maximum.

- Behavioral health benefits are provided through the OptumHealth Behavioral Solutions network of providers.

- Participants have a lifetime maximum (with the exception of outpatient prescription drugs) of $150,000. The first $3,500 paid out annually does **not** apply to the lifetime maximum. If you reach the $150,000, the Plan will only pay $3,500 per year in benefits.

Member Resources:

UnitedHealthcare Member Service
(877) 835-9855
Access to UHC member services 24 hours a day, seven days a week

OptumHealth Behavioral Solutions
(866) 828-6049
Access to OptumHealth Behavioral Solutions member services

Optum NurseLine (800) 563-0416
Provides access to a 24-hour nurse advice line

Care Coordination
Gives you personal support and easy access to information that will help you manage your health or condition, and make smart choices for the future. Contact UHC member services to find out more about this program.

Personal Health Support and Disease Management
Management programs for chronic conditions, complex health care needs and assistance with treatment decisions with comprehensive programs for coronary artery disease, diabetes, heart failure, and asthma. Contact UHC member services to find out more about these programs.

Comprehensive Website www.myuhc.com
Provides access to health information, to print Explanation of Benefits (EOB) online, order a new or replacement ID card or print a temporary ID card; personal health assessments and more.

UnitedHealth Allies (800) 860-8773
Save 10 to 50 percent on many health care products and services not paid for by your plan. Visit www.unitedhealthallies.com to learn more.

Selecting a Network Provider:

For a listing of in-network providers, you can go to the online Provider directory at www.myuhc.com. The username and password is SNL.

Additional Information:

For additional information on this Plan, refer to the UnitedHealthcare Senior Premier PPO Summary Plan Description Appendix A at http://www.sandia.gov/benefits/spd/pdfs/UHC%20Senior%20Premier%20PPO%20Plan%20January%202006%207-25-06.pdf, and the Retiree Medical Plans Comparison Chart.

CIGNA IN-NETWORK PLAN

This medical plan is administered by CIGNA HealthCare. This Plan is an HMO look-alike plan. This Plan provides an open access network, which means that members can see any in-network specialist without a referral. Benefits are available only from in-network (CIGNA-contracted) providers. There is no out-of-network coverage under this Plan.

CIGNA In-Network Plan Key Points

Eligibility:

This Plan is available to non-Medicare retirees, survivors, LTD terminees and their eligible non-Medicare eligible Class I dependents. See "Eligibility Guidelines for Retirees" section for 2009 changes.

Notes:

- Class II dependents are not eligible.
- Medicare-primary individuals are not covered under this Plan (including those with end-stage renal disease who become Medicare primary)
- If your eligible dependent is Medicare-primary, and you enroll in this Plan, you can enroll your dependent(s) in the Lovelace Senior Plan.

Plan Changes Effective January 1, 2009

- New Pharmacy Vendor - Catalyst Rx - See Prescription Drug Coverage for UHC Premier PPO Plan, UHC Senior PPO Plan and CIGNA In-Network Plan change for detail
- Office Visit – Primary Care Physician from $15 to $20 copay
- Office Visit – Specialist from $25 to $30 copay
- Allergy Testing from $25 to $30 copay
- Emergency Room from $100 per visit to $125 per visit
- Outpatient Surgery from $100 to $125 copay
- Chiropractic, Acupuncture, Speech, Physical, and Occupational Therapy from $15 to $20 copay
- Inpatient Admission (Medical and Behavioral Health) - from $200 per day up to $500 maximum to a single $400 copay per admission
- Ambulance from $50 to $75 copay
- Hypnotherapy and biofeedback are no longer covered

Guidelines:

- The prescription drug program is administered through Catalyst Rx. See Prescription Drug Coverage for UHC Premier PPO Plan, UHC Senior Premier PPO Plan and CIGNA In-Network Plan.
- Prescription drug copays do not apply to the out-of-pocket maximums.
- Coverage is provided for services from in-network providers only.
- Emergency and urgent care needs are covered at the in-network benefit level. Any follow-up care must be received from an in-network provider.
- Copays apply to your annual out-of-pocket maximum, except for prescription drugs. The out-of-pocket maximum is your total financial

responsibility for covered medical expenses before the Plan reimburses additional covered charges at 100% for the remaining portion of the calendar year.

- You or a family member must call CIGNA within 48 hours (or as soon as reasonably possible) whenever hospitalized for any out-of-network emergency care. Call CIGNA Member Services at (800) CIGNA24 (244-6224) for details.

Member Resources:

CIGNA Member Services (800) CIGNA24 or (800) 244-6224
Member Services hours: Monday through Thursday, from 8:00 a.m. to 6:00 p.m.

Nurse Advice Line (800) 564-9286
Access to a 24-hour nurse advice line available 24 hours a day, seven days a week

"Well Aware for Better Health"
This is a voluntary program to help members manage chronic conditions for asthma, diabetes, heart disease, low back pain, and chronic obstructive pulmonary disease. Members receive personalized guidance and support from an experienced registered nurse, as well as receive reminders about important screenings and exams.

Comprehensive Website www.mycigna.com
Provides access to health information, to print Explanation of Benefits (EOB) online, order a new or replacement ID card or print a temporary ID card and more.

CIGNA Healthy Rewards (800) 870-3470
Offers discounts to CIGNA members for non-traditional health and wellness programs. Aim for a better and more healthful lifestyle by taking advantage of the discounts. To learn more about the Healthy Rewards providers, call (800) 870-3470 or visit www.cigna.com/healthyrewards.

Selecting a Network Provider:

For a listing of network providers, non-members can access the listing online at www.cigna.com. Select the CIGNA Open Access Only option.

Additional Information:

For additional information on this Plan, refer to the CIGNA In-Network Plan Summary Plan Description at http://www.sandia.gov/benefits/spd/pdfs/SPD%20CIGNA%20In-Network%20Plan_opt%205-1-06.pdf, and the Retiree Medical Plans Comparison Chart.

PRESCRIPTION DRUG COVERAGE FOR UHC PREMIER PPO PLAN, UHC SENIOR PREMIER PPO PLAN AND CIGNA IN-NETWORK PLAN

Prescription Drug Program Key Points

Eligibility:

Members eligible for coverage under the UnitedHealthcare (UHC) Premier PPO Plan, UnitedHealthcare (UHC) Senior Premier PPO Plan and CIGNA In-Network Plan are eligible for the Prescription Drug Program. The Prescription Drug Program is administered by Catalyst Rx. Plan members who have primary prescription drug coverage under another group health care plan are **not** eligible to use the Mail-Order Program or to purchase drugs from retail network pharmacies at the copayment level.

> **Important**: If you are Medicare eligible, you are not required to enroll in a Medicare drug plan. If you and/or your covered dependents enroll in a Medicare Part D prescription drug plan for 2009, refer to the Creditable Coverage Disclosure Notice for 2009 for information on how this may impact your prescription drug coverage through Sandia.

UHC Premier and Senior Premier Plan Changes Effective January 1, 2009

Prescription Drug – Mail Order (maximum 90-day supply)

- Generic – from $18 copay to 20% of mail order price with $12 minimum and $24 maximum
- Preferred Brand – from $65 copay to 30% of mail order price with $50 minimum and $80 maximum
- Non Preferred Brand – from $100 copay to 40% of mail order price with a $80 minimum and $120 maximum
- New Mandatory Specialty Drug Program – see Guidelines below for more detail

CIGNA In-Network Prescription Plan Changes Effective January 1, 2009

New Prescription Drug Vendor: Catalyst Rx

Retail (maximum 30-day supply)

- Generic – from $10 copay to 20% of retail network price with $6 minimum and $12 maximum
- Preferred Brand – from $30 copay to 30% of retail network price with $25 minimum and $40 maximum
- Non Preferred Brand – from not a covered benefit to 40% of retail network price with a $40 minimum and $60 maximum

Mail Order (maximum 90-day supply)

- Generic – from $20 copay to 20% of mail order price with $12 minimum and $24 maximum
- Preferred Brand – from $60 copay to 30% of mail order price with $50 minimum and $80 maximum
- Non Preferred Brand – from not a covered benefit to 40% of mail order price with a $80 minimum and $120 maximum
- New Mandatory Specialty Drug Program – see Guidelines below for more detail

Guidelines:

Special Notes for CIGNA In-Network Members

- Catalyst Rx has its own preferred drug list, therefore, the cost for one or more of your prescription drugs could change due to a modification in the preferred brand/non-preferred brand status of the drug. To find out if your prescription drug is preferred or not, go to www.catalystrx.com or call Catalyst Rx at (866) 854-8851.
- Lovelace Pharmacies are in the Catalyst Rx network.
- Details on the transition of your mail order prescription(s) will be provided by Catalyst Rx via communication to your home, so watch for this!

Mandatory Specialty Drug Program Overview

In order to receive coverage for specialty medications, these drugs must be purchased through the Catalyst Rx Specialty Drug Management Program. These drugs are delivered via mail order through the Specialty Pharmacy (Walgreens/MedMark). All specialty prescriptions will be limited to a 30 day supply and will be subject to the retail coinsurance/copay structure (e.g., 30% coinsurance with a $25 minimum copay and $40 maximum copay for a preferred brand drug). If you are currently taking a specialty medication, you will be contacted by a Walgreens/MedMark Specialty Care Team member by December 15 to assist in the transition of your prescription to prevent any disruption in your medication therapy. If you don't hear from Walgreens/MedMark by this date, please contact Walgreens/MedMark at 866-823-2712 for assistance. To find out whether a drug you are taking is considered a specialty medication, see the "Catalyst Rx Specialty Drug Management Program: Drug List" located in this booklet.

- You must show your Catalyst Rx identification card to obtain the applicable copayment at a retail network pharmacy. If you do not show your Catalyst Rx identification card upon purchase to identify you as a Sandia participant, you will not be eligible for any reimbursement.
- Maximum of 30-day supply at retail network and out-of-network retail pharmacies.
- Reimbursement for a paper claim submitted for purchases at in-network pharmacies will not be allowed (except for coordination of benefits).
- Prescriptions drug copayments and/or coinsurance do not apply to the UHC Premier PPO Plan deductibles or out-of-pocket maximum.
- Prescription drug copayments and/or coinsurance do not apply to the UHC Senior Premier PPO Plan or CIGNA In-Network Plan out-of-pocket maximum.
- If the actual cost of the prescription through the mail or at a retail network pharmacy is less than the copayment, you will only pay the actual cost.
- Under the mail-order program, unless your physician specifies that the prescription be dispensed as written, prescriptions will be filled with the least expensive acceptable generic equivalent when available and permissible by law.
- Under the mail-order program, you must ask for a 90-day prescription with refills in 90-day increments.

- Certain prescriptions will only be dispensed with an appropriate medical diagnosis through the prior authorization process. In addition, some drugs may be subject to step therapy protocol. For more information, call Catalyst Rx at (866) 854-8851.

- Introduction of a new drug to the market does not guarantee coverage of that drug under the Prescription Drug Program.

Important for New Enrollees in the Catalyst Rx prescription drug program

Catalyst Rx "welcome kits" containing your new identification cards, mail order forms and envelope with mail order transition information, an abbreviated preferred brand-name drug list, as well as other important information will be mailed to home addresses in late December.

Member Resources:

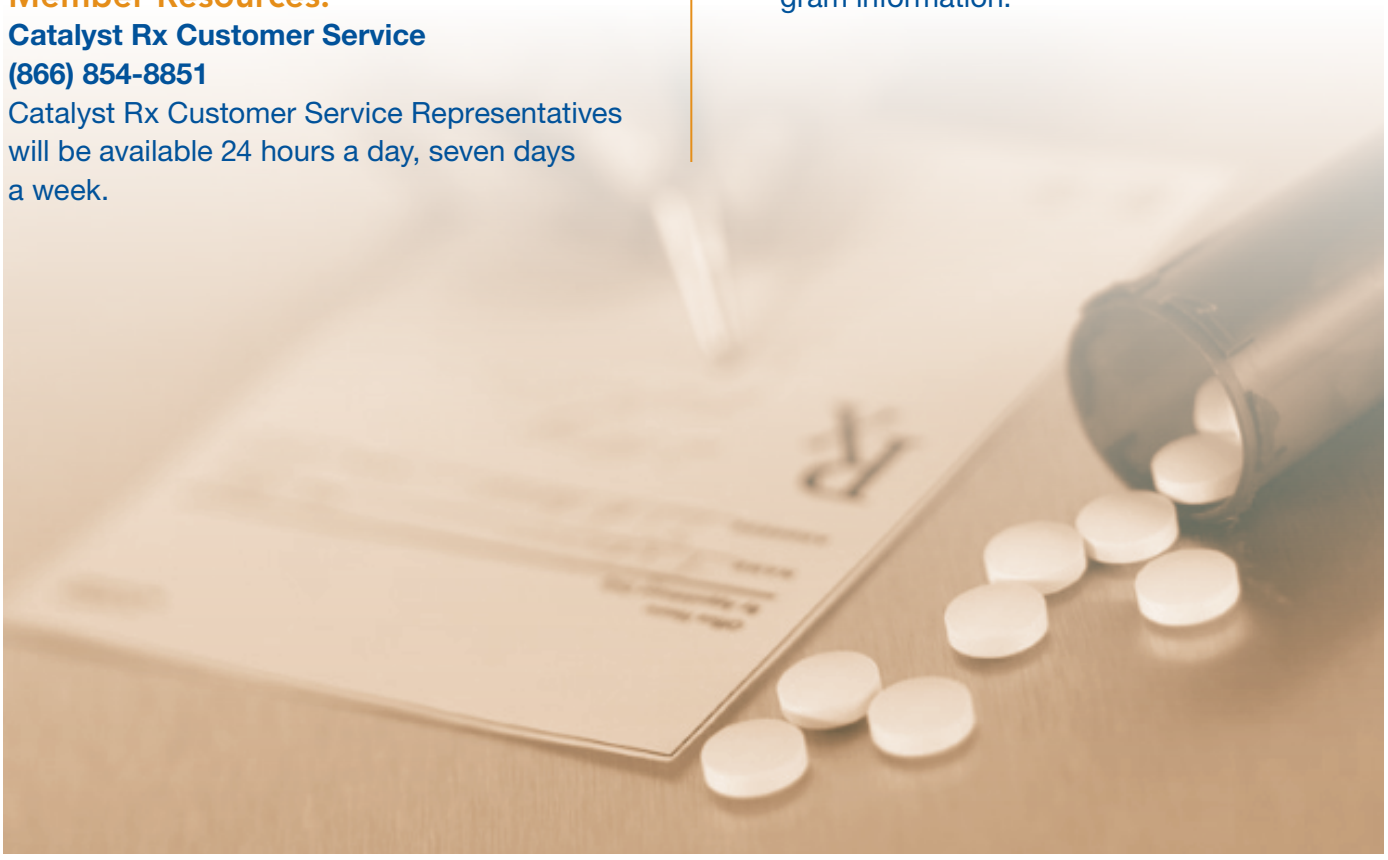
Catalyst Rx Customer Service
(866) 854-8851
Catalyst Rx Customer Service Representatives will be available 24 hours a day, seven days a week.

Walgreens/MedMark (866) 823-2712
Walgreens Specialty Pharmacy customer service offers support, counseling and assistance with medication management Monday through Friday, 6:00 a.m. to 5:00 p.m. (MST).

Interactive Website www.catalystrx.com (user id and password: SNL)
You can view the details of your benefit program, locate a participating pharmacy, or locate the plan formulary.

For additional information on this Plan, refer to the UHC Premier or UHC Senior Premier PPO Plan at http://www.sandia.gov/resources/emp-ret/spd/index.html, and the Retiree Medical Plans Comparison Chart

Note: The CIGNA In-Network Plan Summary Plan Description will be updated in early 2009 to include the Catalyst Rx prescription program information.



LOVELACE SENIOR PLAN (LSP)

The Lovelace Senior Plan (LSP) is a Medicare Advantage Managed Care Plan with prescription drug benefits. This Plan is fully-insured through the Lovelace Health Plan for eligible Medicare-primary participants who live in New Mexico. Benefits are available only from providers who are in the Lovelace Health System network.

Lovelace Senior Plan Key Points

Eligibility:

This Plan is available to Medicare-primary retirees, survivors, LTD terminees and their eligible Medicare-primary Class I dependents. See "Eligibility Guidelines for Retirees" section for 2009 changes. Additionally, you are eligible for membership if you are:

- Entitled to Medicare Part A and are enrolled in Medicare Part B,
- Not receiving benefits due to end-stage renal disease (with a few exceptions), and
- Continue to pay your Medicare Part B premiums after joining the Lovelace Senior Plan.

Notes:

- In order to enroll in this plan, you or your dependents must be Medicare primary on January 1, 2009. If your eligible dependent is non-Medicare, and you enroll in this Plan, you can enroll your dependent(s) in the CIGNA In-Network Plan.

- Class II dependents are not eligible.

Plan Changes Effective January 1, 2009*:

- Office Visit Primary Care and Annual Routine Physical from $5 to $10 copay

Guidelines*:

- Primary Care Physician (PCP) is required. You must select a PCP or one will be assigned to you. Obtain a directory by contacting Lovelace Customer Care Center, Albuquerque Metro Area, at (505) 232-1802 or outside the Albuquerque area, call (800) 808-7363 ext. 1802. Lovelace Customer Care Center is available Monday through Friday, 8:00 a.m. to 5:00 p.m.

- No referrals to specialists are required.

- Unlimited prescription drug coverage is available under this Plan.

- By enrolling in this Plan, you will automatically be enrolled in the Medicare Part D prescription drug benefit and will receive all of your prescription drug benefits through this Plan. If you enroll in an individual Medicare Part D prescription drug plan, then you are not eligible for the Lovelace Senior Plan.

- You will be required to assign your Medicare benefits to the Lovelace Health Plan; therefore, you cannot be enrolled in this Plan and another Medicare Advantage Plan or another Medicare Part D plan at the same time.

- You must enroll in Medicare Parts A and B and continue to pay your Part B premium while enrolled in this plan.

- If you plan on traveling outside the service area for more than six (6) months, this Plan may not be appropriate for you because only emergency care and urgently needed care are available while you are outside the service area.

- You must inform the Lovelace Health Plan and/or Sandia Benefits before moving or leaving the service area for more than six (6) months. Your permanent residence must be in the Lovelace Senior Plan service area, which is the state of New Mexico.

- Outside the service area, this Plan covers only emergency care and urgently needed care. If you are hospitalized in a non-participating hospital for emergency care, you or a family member must call Lovelace Customer Care within 48 hours (or as soon as reasonably possible).

*If there are any discrepancies between this and the Evidence of Coverage, then the Evidence of Coverage supersedes.

Member Resources:

Lovelace Nurse Advice Line (877) 725-2552
The information line is available 24 hours a day, seven days a week, with access to a registered nurse and hundreds of medical topics.

Silver Sneakers Fitness Program
This program offers a complimentary basic fitness center membership in certain NM cities. For more information and a list of fitness center locations, visit the web site at www.silversneakers.com.

Selecting Network Provider:

Obtain a directory by contacting Lovelace Customer Care Center, Albuquerque Metro Area, at (505) 232-1802; outside the Albuquerque area, call (800) 808-7363. Lovelace Customer Care Center is available Monday through Friday, 8:00 a.m. to 5:00 p.m.

Important: After Open Enrollment ends, you will be sent an application form from the Lovelace Health Plan that you will be required to complete and return to the Lovelace Health Plan before December 31, 2008, in order to be enrolled in this Plan.

Additional Information:

For additional information on this Plan, refer to Retiree Medical Plans Comparison Chart.

PRESBYTERIAN MEDICARE PREFERRED PROVIDER ORGANIZATION (PPO) PLAN

The Presbyterian MediCare PPO Plan is a Medicare Advantage Plan with prescription drug benefits. This Plan is fully-insured through the Presbyterian Health Plan for eligible Medicare-primary participants who live in New Mexico.

Presbyterian Medicare PPO Plan Key Points

Eligibility:

This Plan is available to Medicare-primary retirees, survivors, LTD terminees and their eligible Medicare-primary Class I dependents. See "Eligibility Guidelines for Retirees" section for 2009 changes. Additionally, you are eligible for membership if you:

- Are entitled to Medicare Part A and are enrolled in Medicare Part B,
- Are not receiving benefits due to end-stage renal disease, and
- Continue paying your Medicare Part B premiums after joining this Plan.

  Notes: In order to enroll in this plan, all eligible dependents must be Medicare primary.

- Class II dependents are not eligible.

Plan Changes Effective January 1, 2009*:

In-Network:
No Change

Out-of-Network:

- Office Visit Primary Care and Physical Exams from $30 to $35 copay
- Outpatient Rehabilitation from $30 to $35 copay
- Durable Medical Supplies from $40 to $50 copay
- Prosthetics from $25 to $50 copay
- Vision eye glasses or contact lenses after cataract surgery from $25 to $50 copay

Prescription Drugs:

- From: Copays until you reach $4,050 in out-of-pocket costs. After your yearly out-of-pocket drug costs reach $4,050, you pay the greater of: $2.25 for generic or preferred brand drug treated as generic. All other drugs with prior authorization $5.60 or 5%, whichever is greater
- To: Copays until you reach $4,350 in out-of-pocket costs. After your yearly out-of-pocket drug costs reach $4,350, you pay the greater of: $2.40 for generic or preferred brand drug treated as generic. All other drugs with prior authorization $6.00 or 5%, whichever is greater

Guidelines*

- Primary Care Physician (PCP) is required. No referrals to specialists are required.
- You must inform the Presbyterian Health Plan and/or Sandia Benefits before moving or leaving the service area for more than six (6) months. Your permanent residence must be in the Presbyterian MediCare PPO service area, which is the state of New Mexico.

- You will be required to assign your Medicare benefits to the Presbyterian Health Plan; therefore, you cannot be enrolled in the Presbyterian MediCare PPO Plan and another Medicare Advantage plan or another Medicare Part D plan at the same time.
- You must enroll in Medicare Parts A and B and continue to pay your Part B premium while enrolled in this Plan.
- Both in- and out-of-network coverage is available. You may go to any Medicare-approved practitioner or provider out of network.
- Coverage is available worldwide for emergency and urgent care.

Prescription Drugs*:

- By enrolling in this Plan, you will automatically be enrolled in the Medicare Part D prescription drug benefit and will receive all of your prescription drug benefits through this Plan. You will not be required to enroll in Medicare Part D or pay the additional Medicare Part D premium.
- Unlimited outpatient prescription drug coverage is provided through the Presbyterian network of pharmacies. This network has over 48,000 contracted pharmacies nationwide.
- Covered drugs under the Presbyterian MediCare PPO Plan may have requirements or limits on coverage such as prior authorization, quantity limits, or step therapy. The Prescription Drug Formulary list of covered drugs will identify the requirements or limits.
- The Presbyterian Health Plan may make changes to their formulary during the year. The Presbyterian Health Plan will notify members when a drug is removed from the formulary, prior authorization is added, quantity limits and/or step therapy restriction are placed on a drug, or if a drug is moved to a higher cost-sharing tier.
- To get updated information about the drugs covered by this Presbyterian MediCare PPO, please visit the Presbyterian website at www.phs.org or call Member Services at (505) 923-6060 or toll free (800) 797-5343, Monday through Friday, 7 a.m. to 6 p.m. TTY/TDD users should call (888) 625-8818.

*If there are any discrepancies between this and the Evidence of Coverage, then the Evidence of Coverage supersedes.

Member Resources:

Presbyterian MediCare Member Services (800) 797-5343
Access to member services representatives, 8 a.m. to 8 p.m., seven days a week

Nurse Advice Line (800) 887-9917
Access to a 24-hour nurse advice line

Healthy Living Programs
Access to health and wellness education such as classes and internet health links, including access to a health risk assessment to identify health habits you can improve, learn about healthful lifestyle techniques, and access health improvement resources.

Presbyterian Health Services (PHS) Programs and Hospital Services
Many specialty programs are available, including the Arthritis Center, Heart Center, Senior Services and more.

A.D.A.M. www.adam.com
A.D.A.M. provides you with a wealth of illustrated health information that simplifies complex health and medical topics. There are more than 10,000

pages of text-based information; 40,000 medical illustrations; 3D computer models; thousands of animations; and interactive tools.

To learn more about these programs, go to www.phs.org or call (800) 979-5343.

Selecting a Network Provider:

You can obtain a directory through the online provider directory at www.phs.org or by calling Presbyterian MediCare PPO Member Services at (800) 979-5343.

Important: After Open Enrollment ends, you will be sent an application form from the Presbyterian Health Plan that you will be required to complete and return to the Presbyterian Health Plan before December 31, 2008, in order to be enrolled in this Plan.

Additional Information:

For additional information on this Plan, refer to the Retiree Medical Plans Comparison Chart.

KAISER PERMANENTE TRADITIONAL PLAN

The Kaiser Permanente Traditional Plan is an HMO plan with prescription drug benefits. This Plan is fully-insured through Kaiser Permanente for eligible non-Medicare primary participants who live in California, within designated service areas.

Kaiser Permanente Traditional Plan Key Points

Eligibility:

This Plan is available to the following who live within a Kaiser-designated service area (currently, Alameda, Contra Costa, Marin, Sacramento, San Francisco, San Joaquin, San Mateo, Solano, and Stanislaus counties are entirely inside a Kaiser service area; service areas for other Northern California counties are determined by specific ZIP codes within those counties).

This plan is available to non-Medicare-primary retirees, survivors, LTD terminees and their non-Medicare-primary Class I dependents (dependents of eligible Class I dependents may also be eligible). See "Eligibility Guidelines for Retirees" section for 2009 changes.

Class II dependents are not eligible.

Plan Changes Effective January 1, 2009:

- Office Visit – Primary Care and Specialist visits from $15 to $20 copay
- Outpatient Surgery from $50 to $100 copay
- Inpatient Admission from $250 to $500 copay per admission

Prescription Drug

- Brand Name – Retail from $25 to $30 copay (up to 30-day supply)
- Brand Name – Mail Order from $50 to $60 copay (up to 100-day supply)

Guidelines:

- Offers integrated health care with one stop access to medical offices, specialty offices, laboratory, pharmacy, and optical services at each facility.
- Kaiser Permanente providers and facilities must be used. If you access care outside the Kaiser Permanente network, your services may not be covered, except for emergency, urgent care and Kaiser coordinated out-of-network services.
- Self-referral to selected specialty departments; others require a referral from your Plan physician.
- You must reside within a Kaiser Permanente service area to be eligible for the Plan and may only leave the service area for a maximum of 90 continuous days. Exception: Students attending school outside the service area
- Coverage is available worldwide for emergency and urgent care.

Member Resources:

Member Services Call Center (800) 464-4000
Kaiser member services is available weekdays, 7 a.m. to 7 p.m., and weekends, 7 a.m. to 3 p.m.

Nurse Advice Line
Provides access to a 24-hour nurse advice line available 24 hours a day, seven days a week. You can find your region's nurse advice line through the Kaiser Your Guidebook provided to new members, or call (800) 464-4000 to locate your region's nurse advice line resource phone number.

Comprehensive Website www.kponline.org
Provides members the ability to make appointments, consult an advice nurse or pharmacist, on-line health assessment, health-care information, customized online health improvement programs, and more.

Health and Wellness
Health education in the form of videos, reading materials, and free take-home literature are available at every Kaiser Permanente facility. In addition, Kaiser offers a wide variety of health education classes on topics such as first aid/accident prevention, nutrition, smoking cessation, and stress reduction.

Chiropractic Benefit - American Specialty Health Plans of CA (800) 678-9133
Provides direct access to American Specialty Health Plans (ASH) network of participating chiropractors. To learn more about the ASH providers, visit the website at www.ashcompanies.com.

Healthyroads www.healthyroads.com
An innovative health improvement program that helps you take charge of your health through a variety of online tools, including a personal health assessment and a customized exercise planning program. To learn more about the discounts available, go the Healthyroads website.

Additional Information:

For additional information on this Plan, refer to the Kaiser Traditional HMO Plan Summary Plan Description, Kaiser Traditional HMO Plan Evidence of Coverage and Kaiser Chiropractic Evidence of Coverage at http://www.sandia.gov/resources/emp-ret/spd/index.html, and the Retiree Medical Plans Comparison Chart.

KAISER SENIOR ADVANTAGE PLAN (KPSA)

The Kaiser Senior Advantage Plan is a Medicare Advantage Plan with prescription drug benefits. This Plan is fully-insured through Kaiser Permanente for eligible Medicare-primary participants who live in California, within Kaiser-designated service areas.

Kaiser Senior Advantage Plan Key Points

Eligibility:

This Plan is available to the following who live within a Kaiser-designated service area (currently, Alameda, Contra Costa, Marin, Sacramento, San Francisco, San Joaquin, San Mateo, Solano, and Stanislaus counties are entirely inside a Kaiser service area; service areas for other Northern California counties are determined by specific ZIP codes within those counties).

This plan is available to Medicare-primary retirees, survivors, LTD terminees and their Medicare-primary Class I dependents. See "Eligibility Guidelines for Retirees" section for 2009 changes.

Note: Class II dependents are not eligible.

Plan Changes Effective January 1, 2009:
No change

Guidelines:

- Integrated health care with one stop access to medical offices, specialty offices, laboratory, pharmacy, and optical services at each facility.
- Kaiser Permanente providers and facilities must be used. If you access care outside Kaiser Permanente, your services may not be covered, except for emergency and urgent care.
- Self-referral to selected specialty departments; others require a referral from your Plan physician.
- You must reside within a Kaiser Permanente service area to be eligible for the Plan and may only leave the service area for a maximum of 90 continuous days. Exception: Students attending school outside the service area
- Coverage is available worldwide for emergency and urgent care.
- Medicare benefits must be assigned to Kaiser Permanente. Therefore, you cannot be enrolled in another Medicare Advantage Plan or Medicare Part D Plan at the same time you are enrolled in Kaiser Senior Advantage Plan.
- When you select Senior Advantage, your regular Medicare benefits are provided by Kaiser Permanente. You must maintain your Medicare Parts A and B enrollment in order to keep your Senior Advantage coverage.
- When you select Senior Advantage, you will automatically be enrolled in the new Medicare Part D prescription drug benefit. You will receive all of your prescription drugs through the Senior Advantage Plan and pay the Senior Advantage prescription drug copays based upon the specific drug and quantity prescribed. You will not be required to pay the additional Medicare Part D premium to Medicare or the Senior Advantage Plan.

- Medicare will not pay for any medical care you receive from a non-Kaiser Permanente health care provider unless you have been referred to the outside provider by a Kaiser Permanente physician. When you enroll in Senior Advantage, you agree to receive all your medical services through Kaiser Permanente, except for emergencies, urgent out-of-area care, or authorized referrals.

- Senior Advantage is designed for people who live in the Kaiser Permanente service area. If you plan to leave the service area for more than 90 days or move permanently outside the service area, you must disenroll from Senior Advantage.

Member Resources:

Member Services Call Center (800) 464-4000
Kaiser member services is available weekdays, 7 a.m. to 7 p.m., and weekends, 7 a.m. to 3 p.m.

Nurse Advice Line
Provides access to a 24-hour nurse advice line available 24 hours a day, seven days a week. You can find your region's nurse advice line through the Kaiser Your Guidebook provided to new members, or call (800) 464-4000 to locate your region's nurse advice line resource phone number.

Comprehensive Website www.kponline.org
Provides members the ability to make appointments, consult an advice nurse or pharmacist, on-line health assessment, health-care information, customized online health improvement programs, and more.

Health and Wellness
Health education in the form of videos, reading materials, and free take-home literature are available at every Kaiser Permanente facility. In addition, Kaiser offers a wide variety of health education classes on topics such as first aid/accident prevention, nutrition, smoking cessation, and stress reduction.

Chiropractic Benefit - American Specialty Health Plans of CA (800) 678-9133
Provides direct access to American Specialty Health Plans (ASH) network of participating chiropractors. To learn more about the ASH providers, visit the website at www.ashcompanies.com.

Healthyroads www.healthyroads.com
An innovative health improvement program that helps you take charge of your health through a variety of online tools, including a personal health assessment and a customized exercise planning program. To learn more about the discounts available go the Healthyroads website.

Additional Information:

For additional information on this Plan, refer to the Kaiser Senior Advantage Plan Summary Plan Description, Kaiser Senior Advantage Plan Evidence of Coverage, and Kaiser Chiropractic Evidence of Coverage at http://www.sandia.gov/resources/emp-ret/spd/index.html, and Retiree Medical Plans Comparison Chart.

DENTAL CARE PLAN

Effective January 1, 2009, Sandia will offer the Dental Care Plan which replaces the Dental Expense Plan. This Plan will be administered by Delta Dental of Michigan.

Dental Care Plan Key Points

Eligibility:

This Plan is available to retired employees and their eligible dependents.

Highlights:

- Coinsurance coverage based on a percentage of the maximum approved fee for the following types of services:
  - Basic and restorative services that include fillings, extractions, endodontic and periodontal services will be covered at 80%
  - Major services such as crowns, prosthodontics, and specified implant procedures will be covered at 50%
  - Orthodontic services will be covered at 50%
  - Preventive services such as oral examinations, routine cleanings, and x-rays will be covered at 100%
- Annual deductible of $50 per individual up to a family annual maximum deductible of $150
- Annual maximum benefit for non-orthodontic covered services is $1500
- Lifetime maximum benefit for orthodontic covered services is $1800
- Company-paid plan for employees retired prior to December 31, 2008
- Employees that hired prior to January 1, 2009 and retire after December 31, 2008, pay a premium share
- Employees that hire and retire after January 1, 2009, pay the full premium

Additional Information:

Additional plan information will be posted at http://www.oe.sandia.gov. A new Dental Care Plan Summary Plan Description will be sent to all plan participants in calendar year 2009.

DENTAL CARE PLAN PREMIUMS

Monthly Premiums Effective January 1, 2009

Employees Who Retired Prior to December 31, 2008

Employees who retired prior to December 31, 2008, will not be required to pay a dental premium share for themselves or any eligible Class I dependents at this time.

Employees Who Hired Prior to January 1, 2009, and Retired after December 31, 2008

Employees who hired prior to December 31, 2008 and retired on or after January 1, 2009, pay a monthly dental premium share. The monthly premium amount will be deducted from your pension check. Rates are based on retiree, retiree plus one, or retiree plus three or more eligible dependents. Use the table below to find your rate for the Dental Care Plan.

Family Count	Dental Care Plan
Retiree Only	$8.00
Retiree + 1	$15.00
Retiree + 2 or more	$20.00

Employees Who Hired (or Rehired) and Retired after December 31, 2008

Employees who hired and retired after December 31, 2008, pay the full monthly dental premium. The monthly premium amount will be deducted from your pension check. Rates are based on retiree, retiree plus one, or retiree plus three or more eligible dependents. Use the Table below to find your rate for the Dental Care Plan.

Family Count	Dental Care Plan
Retiree Only	$38.00
Retiree + 1	$74.00
Retiree + 2 or more	$98.00

Note: Surviving spouses and LTD Terminees are not eligible for the Sandia Dental Care Plan.

MEDICAL PREMIUM SHARING

Monthly Premiums Effective January 1, 2009

Employees Who Retired Prior to January 1, 1995

Employees who retired prior to January 1, 1995, will not be required to pay a premium share for themselves or any eligible Class I dependents at this time. (Exception: Retirees who retired prior to January 1, 1995, but who currently pay a portion of their medical coverage will continue to do so.)

Employees Who Retired After December 31, 1994, and Before January 1, 2003

All employees who retired after December 31, 1994, pay a monthly premium for coverage in Sandia's medical plans. The monthly premium share amount will be deducted from your pension check. Rates will vary according to your plan choice(s). Use Table A to find your rate for your selected plan(s).

Employees Who Retired After December 31, 2002

Employees who retired after December 31, 2002, pay a percentage of the full premium based on years of service. The monthly premium share amount will be deducted from your pension check. Rates will vary according to your plan choice(s). Use Tables A through E to find your rate for your selected plans(s).

Employees Who Hired and Retired after December 31, 2008

Employees who hired and retired after December 31, 2008, pay the full medical premium. The monthly premium amount will be deducted from your pension check. Rates will vary according to your plan choice(s). Use Table F if you hired and retired after December 31, 2008.

Class II Dependents:

Effective January 1, 2009 – No new Class II Dependents can be enrolled in any of the Sandia medical plans.

All Class II Dependents currently enrolled under a medical plan will be grandfathered.

Retirees who had a Class II Dependent enrolled prior to December 31, 2008:

- Class II dependents for whom you currently pay a Class II premium will not be counted as dependents in calculating the premiums stated above.

- Any Class II dependents for which you do not pay the full Class II premium will be counted as dependents for premium sharing in the calculation.

The monthly premium for a non-Medicare Class II dependent is:

- $508.20 for the UnitedHealthcare Premier PPO Plan

The monthly premium for a Medicare Class II dependent is:

- $196.00 for the UnitedHealthcare Senior Premier PPO Plan

Table A (Retired after 12/31/1994 and before 1/1/03 OR after 1/1/03 with 30+ years)

Medicare Family (everyone in your family is Medicare-primary)

Number of Medicare	UHC Senior Premier PPO	Presbyterian MediCare PPO[1]	Lovelace Senior Plan[1]	Kaiser Senior Advantage Plan[1]
1	$28	$14	$7	$25
2	$56	$28	$13	$51

Non-Medicare Family (no one in your family is Medicare-primary)

Number of Non-Medicare	UHC Premier PPO	CIGNA In-Network Plan	Kaiser Permanente Traditional HMO
1	$73	$72	$60
2	$145	$144	$120
3	$218	$216	$170

Mixed Medicare and Non-Medicare Family (your family has both Medicare-primary and non-Medicare-primary members)

Medicare	Non-Medicare	UHC Senior Premier PPO / UHC Premier PPO	Presbyterian MediCare PPO[3] / UHC Premier PPO	Lovelace Senior Plan[2] / CIGNA In-Network Plan	Kaiser Senior Advantage Plan / Kaiser Permanente Traditional HMO
1	1	$101	$87	$79	$86
2	1	$129	$101	$85	$101
1	2	$173	$159	$151	$136

[1]Rates for Presbyterian MediCare PPO Plan, the Lovelace Senior Plan, and the Kaiser Senior Advantage Plan are subject to change based on Centers for Medicare and Medicaid (CMS) approval.

[2]The combination Lovelace Senior Plan with CIGNA In-Network Plan is available for new enrollment.

[3]The combination Presbyterian MediCare with UHC Premier is no longer available for new enrollment. These rates apply only to **previous** retirees enrolled in this combination plan.

Table B (Employees who retired after 12/31/2002 with 25-29 years)

Medicare Family (everyone in your family is Medicare-primary)

Number of Medicare	UHC Senior Premier PPO	Presbyterian MediCare PPO[1]	Lovelace Senior Plan[1]	Kaiser Senior Advantage Plan[1]
1	$42	$21	$10	$38
2	$84	$43	$20	$76

Non-Medicare Family (no one in your family is Medicare-primary)

Number of Non-Medicare	UHC Premier PPO	CIGNA In-Network Plan	Kaiser Permanente Traditional HMO
1	$109	$108	$90
2	$218	$216	$181
3	$327	$324	$255

Mixed Medicare and Non-Medicare Family (your family has both Medicare-primary and non-Medicare-primary members)

Medicare	Non-Medicare	UHC Senior Premier PPO	Presbyterian MediCare PPO[3]	Lovelace Senior Plan[2]	Kaiser Senior Advantage Plan
		UHC Premier PPO	UHC Premier PPO	CIGNA In-Network Plan	Kaiser Permanente Traditional HMO
1	1	$151	$130	$118	$128
2	1	$193	$152	$128	$151
1	2	$260	$239	$226	$203

[1]Rates for Presbyterian MediCare PPO Plan, the Lovelace Senior Plan, and the Kaiser Senior Advantage Plan are subject to change based on Centers for Medicare and Medicaid (CMS) approval.

[2]The combination Lovelace Senior Plan with CIGNA In-Network Plan is available for new enrollment.

[3]The combination Presbyterian MediCare with UHC Premier is no longer available for new enrollment. These rates apply only to **previous** retirees enrolled in this combination plan.

Table C (Employees who retired after 12/31/2002 with 20-24 years)

Medicare Family (everyone in your family is Medicare-primary)

Number of Medicare	UHC Senior Premier PPO	Presbyterian MediCare PPO[1]	Lovelace Senior Plan[1]	Kaiser Senior Advantage Plan[1]
1	$70	$36	$17	$64
2	$140	$71	$34	$127

Non-Medicare Family (no one in your family is Medicare-primary)

Number of Non-Medicare	UHC Premier PPO	CIGNA In-Network Plan	Kaiser Permanente Traditional HMO
1	$182	$180	$150
2	$363	$360	$301
3	$545	$540	$426

Mixed Medicare and Non-Medicare Family (your family has both Medicare-primary and non-Medicare-primary members)

Medicare	Non-Medicare	UHC Senior Premier PPO / UHC Premier PPO	Presbyterian MediCare PPO[3] / UHC Premier PPO	Lovelace Senior Plan[2] / CIGNA In-Network Plan	Kaiser Senior Advantage Plan / Kaiser Permanente Traditional HMO
1	1	$252	$217	$197	$214
2	1	$322	$253	$214	$252
1	2	$433	$399	$377	$339

[1]Rates for Presbyterian MediCare PPO Plan, the Lovelace Senior Plan, and the Kaiser Senior Advantage Plan are subject to change based on Centers for Medicare and Medicaid (CMS) approval.

[2]The combination Lovelace Senior Plan with CIGNA In-Network Plan is available for new enrollment.

[3]The combination Presbyterian MediCare with UHC Premier is no longer available for new enrollment. These rates apply only to **previous** retirees enrolled in this combination plan.

Table D (Employees who retired after 12/31/2002 with 15-19 years)

Medicare Family (everyone in your family is Medicare-primary)

Number of Medicare	UHC Senior Premier PPO	Presbyterian MediCare PPO[1]	Lovelace Senior Plan[1]	Kaiser Senior Advantage Plan[1]
1	$98	$50	$23	$89
2	$196	$99	$47	$178

Non-Medicare Family (no one in your family is Medicare-primary)

Number of Non-Medicare	UHC Premier PPO	CIGNA In-Network Plan	Kaiser Permanente Traditional HMO
1	$254	$252	$211
2	$508	$504	$421
3	$762	$756	$596

Mixed Medicare and Non-Medicare Family (your family has both Medicare-primary and non-Medicare-primary members)

Medicare	Non-Medicare	UHC Senior Premier PPO	Presbyterian MediCare PPO[3]	Lovelace Senior Plan[2]	Kaiser Senior Advantage Plan
		UHC Premier PPO	UHC Premier PPO	CIGNA In-Network Plan	Kaiser Permanente Traditional HMO
1	1	$352	$304	$275	$300
2	1	$450	$354	$299	$353
1	2	$606	$558	$527	$474

[1]Rates for Presbyterian MediCare PPO Plan, the Lovelace Senior Plan, and the Kaiser Senior Advantage Plan are subject to change based on Centers for Medicare and Medicaid (CMS) approval.

[2]The combination Lovelace Senior Plan with CIGNA In-Network Plan is available for new enrollment.

[3]The combination Presbyterian MediCare with UHC Premier is no longer available for new enrollment. These rates apply only to **previous** retirees enrolled in this combination plan.

Table E (Employees who retired after 12/31/2002 with 10-14 years)

Medicare Family (everyone in your family is Medicare-primary)

Number of Medicare	UHC Senior Premier PPO	Presbyterian MediCare PPO[1]	Lovelace Senior Plan[1]	Kaiser Senior Advantage Plan[1]
1	$126	$64	$30	$115
2	$252	$128	$60	$229

Non-Medicare Family (no one in your family is Medicare-primary)

Number of Non-Medicare	UHC Premier PPO	CIGNA In-Network Plan	Kaiser Permanente Traditional HMO
1	$327	$324	$271
2	$653	$648	$542
3	$980	$972	$766

Mixed Medicare and Non-Medicare Family (your family has both Medicare-primary and non-Medicare-primary members)

Medicare	Non-Medicare	UHC Senior Premier PPO / UHC Premier PPO	Presbyterian MediCare PPO[3] / UHC Premier PPO	Lovelace Senior Plan[2] / CIGNA In-Network Plan	Kaiser Senior Advantage Plan / Kaiser Permanente Traditional HMO
1	1	$453	$391	$354	$385
2	1	$579	$455	$384	$454
1	2	$779	$717	$678	$610

[1]Rates for Presbyterian MediCare PPO Plan, the Lovelace Senior Plan, and the Kaiser Senior Advantage Plan are subject to change based on Centers for Medicare and Medicaid (CMS) approval.

[2]The combination Lovelace Senior Plan with CIGNA In-Network Plan is available for new enrollment.

[3]The combination Presbyterian MediCare with UHC Premier is no longer available for new enrollment. These rates apply only to **previous** retirees enrolled in this combination plan.

Table F (Employee that hired and retired after December 31, 2008)

Medicare Family (everyone in your family is Medicare-primary)

Number of Medicare	UHC Senior Premier PPO	Presbyterian MediCare PPO	Lovelace Senior Plan	Kaiser Senior Advantage Plan
1	$280	$142	$67	$254.60
2	$560	$284	$134	$509.20

Non-Medicare Family (no one in your family is Medicare-primary)

Number of Non-Medicare	UHC Premier PPO	CIGNA In-Network Plan	Kaiser Permanente Traditional HMO
1	$726	$720	$601.69
2	$1,452	$1,440	$1,203.40
3	$2,178	$2,160	$1,702.80

LONG-TERM DISABILITY (LTD) TERMINEE MEDICAL PLAN PREMIUM SHARING

MONTHLY PREMIUMS EFFECTIVE JANUARY 1, 2009

The LTD terminee monthly medical premiums vary based on when you became an LTD terminee.

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

Employees who became an LTD Terminee before January 1, 2003

Medicare Family (everyone in your family is Medicare-primary)

Number of Medicare	UHC Senior Premier PPO	Presbyterian MediCare PPO	Lovelace Senior Plan	Kaiser Senior Advantage Plan
1	$28	$14	$7	$25
2	$56	$28	$13	$51

Non-Medicare Family (no one in your family is Medicare-primary)

Number of Non-Medicare	UHC Premier PPO	CIGNA In-Network Plan	Kaiser Permanente Traditional HMO
1	$73	$72	$60
2	$145	$144	$120

Employees who became an LTD Terminee after December 31, 2002

Medicare Family (everyone in your family is Medicare-primary)

Number of Medicare	UHC Senior Premier PPO	Presbyterian MediCare PPO	Lovelace Senior Plan	Kaiser Senior Advantage Plan
1	$98	$50	$23	$89
2	$196	$99	$47	$178

Non-Medicare Family (no one in your family is Medicare-primary)

Number of Non-Medicare	UHC Premier PPO	CIGNA In-Network Plan	Kaiser Permanente Traditional HMO
1	$254	$252	$211
2	$508	$504	$421

SURVIVING SPOUSE MEDICAL PLAN PREMIUM SHARING

MONTHLY PREMIUMS EFFECTIVE JANUARY 1, 2009

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

- 50 percent of the full experience-rated premium if you are a survivor of a retiree or a regular employee with more than 15 years of service (based on term of employment).
- 100 percent of the full experience-rated premium if you are a survivor of a retiree or a regular employee with less than 15 years of service (based on term of employment).

Important: If you are a surviving spouse and you waive or drop coverage, you can never reenroll in a Sandia-sponsored medical plan.

Note: If you remarry, you are no longer eligible for a Sandia-sponsored medical plan.

Surviving spouse of a retiree or regular employee with more than 15 years of service
Medicare Family (everyone in your family is Medicare-primary)

Number of Medicare	UHC Senior Premier PPO	Presbyterian MediCare PPO	Lovelace Senior Plan	Kaiser Senior Advantage Plan
1	$140	$71	$33.50	$127.30

Non-Medicare Family (no one in your family is Medicare-primary)

Number of Non-Medicare	UHC Premier PPO	CIGNA In-Network Plan	Kaiser Permanente Traditional HMO
1	$363	$360	$300.85
2	$726	$720	$601.70

Rates for Presbyterian MediCare PPO Plan, the Lovelace Senior Plan, and the Kaiser Senior Advantage Plan are subject to change based on Centers for Medicare and Medicaid (CMS) approval.

RETIREE MARRIED TO ACTIVE SANDIAN/OTHER RETIREE

During Open Enrollment, you may elect to cover yourself as

1) an individual or

2) a dependent of your Sandia spouse or

3) the primary covered retiree/employee with your Sandia spouse as a dependent, regardless of your/their salary tier or medical plan choice. Monthly premiums will be based on the primary Sandia participant.

Note: If you are Medicare-eligible, different rules with respect to Medicare apply, depending on if you are covered as the primary participant, an individual, or a dependent of an active Sandian. Call the HBE Customer Service at (505) 844-HBES (4237) for more information.

If you and your Sandia spouse elect to be covered separately, any eligible dependents may be covered under either spouse (e.g., enroll some dependents under one spouse and others under the other spouse, etc.).

Important: No one (employees or eligible dependents) may be covered as both a primary participant and a dependent, or as a dependent under two different Sandia employees/retirees.

If you wish to change your coverage for 2009, both Sandians must do so by completing the Open Enrollment Change Form included in this booklet and returning it by November 10, 2008 (must be postmarked by November 10).

The primary covered retiree/employee must enroll his or her spouse and any other dependents by using the Open Enrollment Change Form.

ELIGIBILITY GUIDELINES FOR RETIREES

Class I Dependents

Eligibility for Coverage under the UnitedHealthcare (UHC) Premier PPO Plan, Presbyterian MediCare PPO Plan, CIGNA In-Network Plan, Lovelace Senior Plan, UHC Senior Premier PPO Plan, and Dental Care Plan (DCP is not available to survivors or LTD terminees).

If you are the primary member under the Plan, your Class I dependents eligible for membership include your:

- Spouse, not legally separated or divorced from you,
- Unmarried dependent child[1] under age 24,
- Unmarried child of any age
  - who is permanently and totally disabled* and is unable to engage in any substantial gainful activity by reason of medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months,
  - who lives with you, in an institution or in a home that you provide,
  - and who is "financially dependent" on you

  Note: The claims administrator determines if the applicant is disabled. Please contact Sandia's Benefits Customer Service Center at (505) 844-HBES (4237) for more information on enrolling your child as an incapacitated dependent.
- Unmarried child who is recognized as an alternate recipient in a "qualified national medical support order" (QNMSO) enforceable with respect to Sandia's plan.

[1]Child includes:

- the primary covered member's own children and legally adopted children
- adopted child (if the placement agreement and/or final adoption papers have been completed and submitted to Sandia Benefits)
- unmarried stepchild of the primary covered member who lives with you at least 50% of the calendar year, or if ages 19 through 23 is a full time student
- child for whom the primary covered member has legal guardianship
- natural child, legally adopted child, or child for whom the primary covered member has legal guardianship if a court decree requires the primary covered member to provide coverage

Eligibility for coverage under the Kaiser Permanente Traditional HMO and the Kaiser Permanente Senior Advantage Plan have the same eligibility requirements as stated above, however, they also include:

- other unmarried dependent persons who meet all of the following requirements (excluding foster children):
- He or she is under age 24,

- He or she receives from you or your spouse all of his or her support and maintenance,
- He or she permanently resides with you (the primary member),
- You or your spouse is the court-appointed guardian (or was before the person reached age 18), or whose parent is an enrolled dependent under your family coverage.

*Kaiser Permanente disabled dependent requires the following additional requirements:

- The dependent is incapable of self-sustaining employment because of mental retardation or physical handicap that occurred **prior to reaching the age limit for dependents**
- Receive substantially all of their support and maintenance from you and your spouse
- You give Kaiser proof of their incapability within 31 days after Kaiser requests it

Note: Kaiser Permanente determines if the applicant is disabled.

Class II Dependents

Effective January 1, 2009 – No new Class II Dependents can be enrolled in any of the Sandia medical plans. All eligible Class II Dependents currently enrolled under a medical plan may continue coverage.

To qualify for medical coverage, a Class II dependent must:

- Be "financially dependent" on you; financially dependent means that a person receives greater than 50% of their financial support for the calendar year from the primary member,
- Have a total income from all sources of less than $15,000/year other than the support you provide, and
- Have lived in your home, or one provided by you in the United States, for the most recent six months.

Note: Class II Dependent annual recertification is required.

Important Notice Regarding Tax Treatment of Benefits for Dependents

The requirements and criteria below are independent of the Sandia health plan eligibility criteria. Retirees are completely responsible for evaluating each dependent to insure it complies with the federal tax law requirements. In the event of an IRS audit, the retiree (not Sandia) is ultimately liable for any findings associated to the audit.

In making your annual benefit elections, please be aware that the Federal tax law may cause some benefits to be taxable in certain circumstances. The Working Families Tax Relief Act of 2004 ("WFTRA") defines two types of dependents for the purposes of health care coverage in the Internal Revenue Code – a "qualifying child" and a "qualifying relative." There are different requirements for each dependent as follows:

To have a dependent status as a "qualifying child", the individual must:

- share the taxpayer's residence for more than half the year,
- be the taxpayer's child, stepchild, sibling, step-sibling or any of the descendants of these relatives; for example, a grandchild, niece or nephew (adopted and qualified foster children are considered the taxpayer's children);

- be under age 19, or under age 24 in the case of a full-time student on the last day of the tax year (no age limit applies to any of the listed individuals if they are totally and permanently disabled); and
- not provide more than half of his or her own support

To have a dependent status as a "qualifying relative", the individual must:

- receive over half of his or her support from the taxpayer,
- not be a "qualifying child" dependent of the taxpayer or any other taxpayer,
- be the taxpayer's child, sibling, step-sibling or any of their descendants; a parent or stepparent or any of their ancestors; an aunt, uncle, niece, or nephew; children-or parents-in-law; or an unrelated individual who shares the taxpayer's residence as a member of their household

Although Congress apparently did not intend the WFTRA to affect the tax treatment of benefits provided to dependents of employees and retirees, in some circumstances, medical benefits may be taxable. We understand that these requirements are confusing. It is important to contact your tax advisor if you have any questions about how these changes may affect you. If your dependent does not meet the "qualifying child" or "qualifying relative", please contact Sandia HBES, so the Benefits department can impute income on any premiums as applicable.

Ineligible Dependents

You must disenroll your ineligible dependents within 31 calendar days. For example, the following lists events that would make your dependents ineligible.

Class I Dependents

- Divorce or annulment
- Legal separation
- Child marries
- Child reaches age 24
- Incapacitated child no longer meets incapacitation criteria

Class II Dependents

- Child, step-child, grandchild, brother or sister marries
- Child, step-child, grandchild, brother, sister, parent, step-parent or grandparent no longer meets Class II eligibility requirements criteria

Note: For allowable mid-year coverage plan changes, refer to the pretax premium plan by contacting the Health, Benefits and Employee Services Customer Service.

ELIGIBILITY, ENROLLMENT, AND DISENROLLMENT FOR SURVIVING SPOUSE OR DEPENDENT OF AN ON-ROLL REGULAR EMPLOYEE OR SANDIA RETIREE

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

Sandia pays a portion of the full premium for surviving spouse to continue health coverage for the first six months.

Exception: Sandia does NOT pay for the first six months of coverage for survivors of those retired employees paying the full monthly premium at the time of death.

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

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

Special Rules

- All Class I and Class II dependents covered at the time of death of the employee are eligible for continued health coverage through Sandia.
- No new dependents can be added, except for children born or adopted with respect to a pregnancy or placement for adoption that occurred before the employee's or retiree's death.
- A survivor cannot add a Class II dependent even if that dependent is a Class I dependent at the time of the employee's death.

Termination Rules

For the surviving spouse and dependents, coverage terminates if:

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

ELIGIBILITY, ENROLLMENT, AND DISENROLLMENT FOR LONG-TERM DISABILITY TERMINEE

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

If you are under age 65 and have been receiving Social Security disability benefits for 24 months or longer, or if you are age 65 or older, you are eligible for Medicare primary coverage. Medicare will become your primary coverage. Upon becoming eligible for primary coverage, you have the option of enrolling in either the UHC Senior Premier PPO Plan or the Presbyterian MediCare Plan (if you have no non-Medicare dependents).

You must notify Sandia in writing within 31 calendar days of becoming eligible for Medicare primary coverage. If you do not notify the Sandia Benefits Department within 31 calendar days of becoming eligible for Medicare primary coverage, you will be defaulted to the UHC Senior Premier PPO Plan (unless as noted otherwise in the following “Important” section).

> **Note**: You can only enroll in the Presbyterian MediCare PPO Plan or Lovelace Senior Plan if you are enrolled in Medicare Parts A and B and do not have Class I non-Medicare or Class II dependents.

Important: Since all Medicare primary family members must be enrolled in the same plan, and all non-Medicare primary family members must be enrolled in the same plan, upon becoming eligible for the UHC Senior Premier PPO Plan or the Presbyterian MediCare PPO Plan, Lovelace Senior Plan, or Kaiser Senior Advantage Plan, if one of the covered family members is already enrolled in one of these plans, you will only be able to enroll in the same plan as your covered family members.

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

ENROLLING AND DISENROLLING DEPENDENTS FOR MEDICAL AND DENTAL COVERAGE

If you want to add a dependent to your coverage, you must do so during Open Enrollment. You can only add a dependent to your coverage outside of Open Enrollment based on an eligible mid-year election change event (e.g., marriage, birth, adoption). If you add a dependent during Open Enrollment, coverage will become effective January 1, 2009.

> **Note**: If you do not enroll a dependent because the dependent has other medical coverage and your dependent involuntarily loses eligibility for that coverage, you may be able to enroll the dependent in your medical plan provided that you request enrollment within 31 calendar days after the other coverage ends.

Class II Dependent Enrollment

Effective January 1, 2009 - Class II Dependent plan eligibility and enrollment has been eliminated.

All Class II Dependents currently enrolled under a medical plan will be grandfathered. Future Class II Dependent disenrollment from the plan will result in plan ineligibility for life.

Disenrolling Ineligible Dependents
You must disenroll any dependent that is no longer eligible for plan coverage within 31 days of becoming ineligible.

You can drop a dependent at any time during the plan year. If a dependent becomes ineligible during the plan year, you must disenroll the dependent within 31 calendar days of the mid-year election change event causing ineligibility. If you fail to disenroll your dependent within 31 calendar days, see section entitled "Consequences of Not Meeting the Disenrollment Requirements."

Note: If you drop a dependent, you can re-enroll eligible dependents during Open Enrollment for coverage effective the following calendar year, or within 31 calendar days of an eligible mid-year election change event.

To add/drop a dependent, you must complete the Open Enrollment Change Form included in this booklet. It must be postmarked by November 10, 2008.

Consequences of Not Meeting the Disenrollment Requirements

- Sandia will take action that results in permanent loss of health plan coverage for you and your dependents for fraudulent use of the Plan.
- Sandia will report the incident to the office of the Inspector General.
- Sandia will retroactively terminate dependent coverage, effective the end of the month in which the dependent became ineligible.
- Sandia will not refund any applicable monthly premiums paid by you during the ineligible period.
- You will be personally liable to refund to Sandia all health care plan claims and/or premiums rendered during the ineligible period.
- Your dependent could lose any rights to temporary, continued health care coverage under COBRA.

IMPORTANT BENEFIT NOTICES

Women's Health and Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act (WHCRA) provides protections for individuals who elect breast reconstruction after a mastectomy and requires employers to inform health plan participants annually about this Act. Under WHCRA, group health plans offering mastectomy coverage must also provide certain services relating to the mastectomy. If you have had or are going to have a mastectomy, you may be entitled to certain benefits under WHCRA. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for the following:

- All stages of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prosthesis
- Treatment of physical complications of the mastectomy, including lymphedema

These benefits will be subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under your medical plan.

Health Insurance and Portability Accountability Act of 1996 Special Enrollment Periods

The Health Insurance and Portability Accountability Act of 1996 (HIPAA) provides rights and protections for participants in group health plans. Under HIPAA, if you waive or drop coverage for yourself and your covered dependents because of other health insurance coverage, and you and/or your covered dependents involuntarily lose eligibility for that coverage, you may be able to enroll yourself and your eligible dependents in a Sandia health plan. To do so, you must request enrollment and notify Benefits within 31 calendar days of the loss of coverage.

In addition, if you are not enrolled in a Sandia-sponsored medical plan and you acquire a new eligible dependent as a result of marriage, birth, adoption, placement for adoption, or obtaining legal guardianship, you may be able to enroll yourself and your eligible dependents in a Sandia health plan. Again, you must request enrollment and notify Benefits within 31 calendar days of the effective date following the event.
In addition, if you are not enrolled in a Sandia-sponsored medical plan and you acquire a new eligible dependent as a result of marriage, birth, adoption, placement for adoption, or obtaining legal guardianship, you may be able to enroll yourself and your eligible dependents in a Sandia health plan. Again, you must request enrollment and notify Benefits within 31 calendar days of the effective date following the event.

MEDICAL PLAN DEFINITIONS

Balance Billing
In the Medicare program, the practice of billing a Medicare beneficiary in excess of Medicare's allowed charge is known as balance billing. The balance billing amount is the difference between Medicare's allowed charge and the provider's actual charge to the patient.

Billed Charges
The amount the provider bills for a service

Centers of Excellence
A special Plan network that provides members and their families with access to medical care at some of the most well-known and respected health care institutions in the United States for technologically advanced procedures including organ transplants, cancer resource services, and congestive heart disease services.

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

CMS
Center for Medicare and Medicaid Services

Coinsurance
Cost-sharing feature by which both the Plan and the covered member pay a percentage of the covered charge

C.O.B. (Coordination of Benefits)
When a covered member has medical coverage under other group health plans (including Medicare), the Plan benefits are reduced so that total combined payments from all plans do not exceed 100% of the Eligible Expense

Copayment/Copay
Cost-sharing feature by which the Plan pays the remainder of the covered charge after the covered member pays his or her portion as a defined dollar amount

Cost-sharing Liability
Cost-sharing is the portion of payment to a provider of health care services that is the liability of the patient. Cost-sharing liabilities include deductibles, copayments, coinsurance, and balance billing amounts.

Covered Charge or Covered Expense
Any expense covered by the Plan during a claim period

Creditable Prescription Drug Coverage
Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage

Deductible
Covered charges incurred during a calendar year that the covered member must pay in full before the Plan pays benefits (with the exception of prescription drugs and certain preventive benefits in-network).

Dual Sandians
Both spouses are employed by and/or retired from Sandia National Laboratories

Durable Medical Equipment (DME)
Equipment determined by the Plan to meet the following criteria:
- is prescribed by a licensed physician
- is medically appropriate

- is not primarily and customarily used for a non-medical purpose
- is designed for prolonged use, and
- serves a specific therapeutic purpose in the treatment of an injury or sickness

Eligible Expenses
(for the UHC plans, formerly referenced as U&C) Charges for Covered Health Services that are provided while the plan is in effect, determined as follows for out-of-network benefits:

- Negotiated rates agreed to by the out-of-network provider and either the Claims Administrator or one of its vendors, affiliates, or subcontractors
- The following:
  - Selected data resources which, in the judgment of the Claims Administrator, represent competitive fees in that geographic area;
  - Fees that are negotiated with the provider;
  - 70% of the billed charge; or
  - A fee schedule that the Claims Administrator develops.

E.O.B. (Explanation of Benefits)
A statement detailing the medical benefits accounts activity for an individual or family.

Health Maintenance Organization (HMO)
A corporation financed by insurance premiums whose member physicians and professional staff provide curative and preventive medicine within certain financial, geographic, and professional limits to enrolled volunteer members and their families.

In-Network
Services that are provided by a Health Care Provider that is a member of the PPO

Inpatient Stay
An uninterrupted confinement of at least 24 hours following formal admission to a hospital, skilled nursing facility or inpatient rehabilitation facility

Long-Term Care
A variety of services that help people with health or personal needs and activities of daily living over a period of time. Long-term care can be provided at home, in the community, or in various types of facilities, including nursing homes and assisted living facilities. Most long-term care is custodial care. Medicare and Sandia medical plans don't pay for this type of care if this is the only kind of care you need.

Maintenance Care
Treatment beyond the point where material or significant improvement is to be expected. The treatment results in no measurable or objective improvement. For modality treatments, such as nonsurgical spinal treatment or physical therapy, the treatment provides no evidence of lasting benefit; treatment provides only relief of symptoms.

Maximum Approved Fee
The maximum fee that can be charged by the dentist for a service (a specific procedure code) provided to a Delta Dental patient, per the contract between Delta Dental and the provider.

Medicaid
A joint Federal and State program that helps with medical costs for some people with limited income and resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medicare Allowable
See "Medicare Approved Amount"

Medicare Approved Amount
In the Original Medicare Plan, this is the amount a doctor or supplier can be paid, including what

Medicare pays and any deductible, coinsurance, or copayment that you pay. It may be less than the actual amount charged by a doctor or supplier; amount Medicare approves for this service or supply.

Medicare Assignment
In the Original Medicare Plan, this means a doctor or supplier agrees to accept the Medicare-approved amount as full payment.

Negotiated Fees
A contractual fee agreed to by providers or facilities and the Claims Administrator for services provided to PPO plan members.

Network Gap Exception (UHC Only)
If there are no in-network providers in the required specialty within a 30-mile radius from the covered member's home, the Plan may grant an exception to allow in-network benefits for services provided by an out-of-network provider.

Non-Preferred Drug
A drug not included on the plan administrator prescription preferred drug list selected as a generic or preferred drug; any preferred name drug for which a generic product becomes available may be designated as a non-preferred product (higher copayment)

Open Enrollment
The period of time every year when you have the option to change your medical coverage for the subsequent calendar year (normally held in the fall of each year)

Out-of-Area Plan
Members who do not have access to Plan network providers within a 30-mile radius of their home will be covered under the in-network level of benefits under the out-of-area plan when they access providers. Reimbursement is based on billed charges.

Out-of-Network
Services provided by a Health Care Provider that is not a member of the Plan's Preferred Provider Organization (PPO), as distinguished from In-Network Services that are provided by a Health Care Provider that is a member of the PPO

Out-of-Pocket Maximum
The member's financial responsibility for covered medical expenses before the Plan reimburses additional covered charges at 100% for the remaining portion of that calendar year (outpatient prescription drugs and non-Medicare office visit copays do not apply to the out of pocket maximum).

Participating Provider
The health care professionals, hospitals, facilities, institutions, agencies, and practitioners with whom the Plan contracts to provide covered services and supplies to Plan participants

Penalty
An amount added to your monthly premium for Medicare Part B, or for a Medicare drug plan (Part D), if you don't join when you are first eligible. You pay this higher amount as long as you have Medicare. There are some exceptions.

Plan Administrator
Sandia National Laboratories

Precertification (see Prior Notification)

Pre-Determination
Process by which the member determines if a service is covered under the Sandia benefit plan. Detailed information is submitted to the health Plan by the physician or member to ensure a complete review.

Preferred Drug
A drug included on the plan administrator preferred drug list selected according to the drug safety, efficacy, therapeutic merit, current standard of practice and cost

Preferred Provider Organization (PPO)
A network of physicians and other health care providers who are under contract to provide services for a negotiated fee

Preventive Services
Health care to keep you healthy or to prevent illness (for example, Pap tests, pelvic exams, flu shots, and certain cancer screenings).

Primary Care Doctor (PCP)
A doctor who is trained to give you basic care. Your primary care doctor is the doctor you see first for most health problems. He or she makes sure that you get the care that you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them.

Prior notification (also known as Pre-certification or Prior Authorization)
The process where the covered member calls the claims administrator to obtain prior approval for certain medical services or procedures.

Service Area
The geographical area, approved by the appropriate staff agency, within which participating providers are accessible to covered members

Skilled Nursing Facility Care
This is a level of care that requires the daily involvement of skilled nursing or rehabilitation staff. Examples of skilled nursing facility care include intravenous injections and physical therapy.

The need for custodial care (such as help with activities of daily living, like bathing and dressing) cannot qualify you for Medicare coverage in a skilled nursing facility if that's the only care you need. However, if you qualify for coverage based on your need for skilled nursing care or rehabilitation, Medicare will cover all of your care needs in the facility, including help with activities of daily living.

Usual & Customary (U&C) Charges (UHC see Eligible Expenses)
Based on the range of fees charged by physicians, health care facilities, or other health care providers in the same geographical area for the same or similar services. CIGNA HealthCare has the exclusive right to determine the usual and customary charges.

OPTION TO WAIVE MEDICAL COVERAGE

You have the option to waive medical coverage for yourself and any dependents. Please review your alternate insurance coverage prior to making your decision to waive your coverage through Sandia's plan. Coverage for any eligible dependents is based on your coverage as a Sandia retiree; therefore, if you waive medical coverage for yourself, you are also waiving coverage for all dependents. If you waive medical coverage, the next opportunity to re-enroll will be the next annual Open Enrollment.

If you are waiving medical coverage for yourself and your dependents because of other medical coverage, and you and/or your dependents involuntarily lose eligibility for that coverage, you may be able to enroll yourself and your dependents during the plan year, provided that you request enrollment within 31 calendar days after the other coverage ends.

In addition, if you gain a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 calendar days after the marriage, birth, adoption, or placement for adoption.

You must complete the Waiver of Medical Coverage Form included in this booklet and it must be received by the Benefits Department by November 10, 2008. If you do not actively waive your medical coverage in Sandia's plan, you are thereby giving authorization to Sandia to deduct the appropriate premium from your pension check beginning January 1, 2009.

Dropping Medical Coverage:

Because you pay premiums on an after-tax basis, you can drop medical coverage for yourself and your dependents at any time throughout the calendar year without an eligible mid-year election change event, with written notification to the Benefits Department, MS 1463.

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

2009 Open Enrollment Appeals

Retiree election changes **after** November 10 will only be considered due to the following: if it is determined the enrollee experienced extenuating circumstance(s) (e.g., international/remote travel or medical emergency for yourself or immediate family member) to support the enrollment request after November 10, 2008. Failing to make your elections because you forgot or did not take the time, is not considered "extenuating circumstances."

If you believe you have experienced extenuating circumstances to support an enrollment change, contact HBES Customer Service (505) 844-HBES (4237) by December 5, 2008.

Waiver of Medical Coverage Form

To waive medical coverage for yourself and your dependents, you must fill out the information requested below and return it to the Benefits Customer Service Center at MS 1463 or Fax: 505-844-7535. (If mailing from outside Sandia, please see complete address below.) This form must be received by the Benefits Department by, November 10, 2008.

I, _____, SSN: _____ waive coverage for myself and all dependents in any of Sandia's medical plans effective January 1, 2009.

I understand the benefit I am waiving and that Sandia is not responsible for any medical expenses incurred by me and/or my dependents during the period in which these benefits are waived.

I also understand that my next opportunity to re-enroll in a Sandia medical plan will be during the Open Enrollment period for the next calendar year or based on an eligible mid-year election change event.

> **Note**: If you waive/drop medical coverage for yourself and your dependents because of other medical coverage and you and/or your dependents involuntarily lose eligibility for that coverage, you may be able to enroll yourself and your dependents during the plan year, provided that you request enrollment within 31 calendar days after your other coverage ends. In addition, if you gain a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 calendar days after the marriage, birth, adoption, or placement for adoption.
>
> **Important**: If you are a surviving spouse and you waive coverage, you can never re-enroll in a Sandia medical plan.

_____ _____

Retiree/Surviving Spouse/LTD Terminee Signature Date

Sandia National Laboratories
PO Box 5800
Albuquerque, New Mexico 87185-1463
Attn: Benefits Customer Service Department, MS 1463

CONTACT LIST

Resource	Phone	Web Address
SNL Health Benefits & Employee Services Customer Service: Retiree Resources Summary Plan Descriptions and Forms:	(505) 844-HBES (4237) or (800) 417-2634, ext. 844-4237	http://hbe.sandia.gov http://www.oe.sandia.gov
UnitedHealthcare Sandia Group #708576 Customer Service: UHC Optum NurseLine: Transplant Resources: Cancer Resources: OptumHealth Behavioral Solutions: UnitedHealth Allies:	 (877) 835-9855 (800) 563-0416 (866) 936-7246 (866) 936-6002 (866) 828-6049 (800) 860-8773	http://www.myuhc.com (use SNL for login/password) http://www.liveandworkwell.com http://unitedhealthallies.com
Catalyst Rx Customer Service: Specialty Drug Program Customer Service: Walgreens/MedMark	(866) 854-8851 (866) 823-2712	http://www.catalystrx.com (use SNL for login/password)
CIGNA Sandia Group #3172368 Customer Service and Nurse Advice Health Information Line: Healthy Rewards:	 (800) 244-6224 (800) 870-3470	 http://www.cigna.com http://www.cigna.com/ healthyrewards
Delta Dental of Michigan Group #9550 Customer Service: Claims Lookup Access Claims Processing Address P.O. Box 9085 Farmington Hills, MI 48333-9085	 (800) 264-2818	 http://www.deltadental.com http://www.toolkitsonline.com

Resource	Phone	Web Address
Lovelace Senior Plan (NM) Customer Service:	(505) 232-1883 or (800) 808-7363 (outside ABQ)	www.lovelacehealthplan.com
Presbyterian MediCare PPO (NM) Customer Service:	(505) 923-6060 (800) 797-5343 (outside ABQ)	www.phs.org
Kaiser (CA) Sandia Group #7455 Customer Service: Healthyroads Discount Plan: American Specialty Health Network:	(800) 464-4000 (877) 330-2746 (800) 678-9133	http://www.kp.org http://www.healthyroads.com http://ashcompanies.com

PREVENTIVE HEALTH BENEFITS

Quick Reference Guide (for employees, retirees and eligible dependents)

Your Sandia medical plan (under UHC or CIGNA) will cover preventive services as outlined below at 100% (in-network services only). The plan will not cover all care that is preventive in nature. It is solely up to the provider (physician, lab technician, and office staff) as to whether a service is coded as preventive or diagnostic. Neither Sandia nor the plan administrator can direct the provider to bill a service in any particular way.

One routine physical/annual exam is allowed each calendar year, regardless of the date of the previous routine physical exam, and no more frequently than one per calendar year. You are eligible for an annual routine physical exam even if you have any type of chronic illness or condition, such as high blood pressure, diabetes, etc. Allowable exams include routine preventive physical, including annual exams and sports physicals.

Benefit	Birth to 2 Years	Ages 3 to 10	Ages 11 to 18	Ages 19 and older
Well-baby/ Well-child/Well-person exam	Birth, 1, 2, 4, 6, 9, 12, 15, 18, & 24 months	Once a year	Once a year	Once a year
Blood pressure		Once a year	Once a year	Once a year
Bone density test				Once every three years, ages 50 and older
Cholesterol screen		Selective screening of children and adolescents at risk due to family history		Once a year complete lipoprotein profile, fasting
Chlamydia screen			Once a year	Once a year
Colon cancer screen				Colorectal cancer screenings, ages 50 and older: • Sigmoidoscopy once every 5 yrs or • Colonoscopy once every 10 yrs or • Sigmoidoscopy or colonoscopy every 5 yrs before age 50 or more frequently if you have an immediate family history of colorectal cancer • Barium enema once every 5 yrs in lieu of a colonoscopy or sigmoidoscopy

Benefit	Birth to 2 Years	Ages 3 to 10	Ages 11 to 18	Ages 19 and older
Complete blood count				Once a year
Complete urinalysis				Once a year
Complete metabolic profile				Once a year
Diabetes screen				Once a year
Fecal occult blood test				Once a year, ages 50 and older
Gardasil (HPV)		Girls ages 9 and older	Girls ages 11 to 18	Women age 9 to age 26
Hearing exam	As needed	As needed		
Hemoglobin/ Hematocrit	Between 9 & 12 months			
Immunizations (including those needed for personal travel)	As needed	As needed	As needed	As needed
Mammogram				Baseline between ages 35-39 and ages 40 and older, once a year
PKU screen	As needed			
PSA				Men ages 50 and older, once a year
Pap test			Girls ages 14 and older, once a year	Women ages 19 and older, once a year

Benefit	Birth to 2 Years	Ages 3 to 10	Ages 11 to 18	Ages 19 and older
Pregnancy related • Multiple marker screen (weeks 15 and 18) • Serum alpha-fetoprotein (weeks 16 and 18) on personal risk factors • Chorionic villus sampling before week 13 • Amniocentesis (between weeks 15 and 18) • Hemoglobiopathy screen • Gestational diabetes screen • Group B strep (between weeks 35 and 37) • Initial screen for anemia, rubella, hepatitis B, and STD				Women ages 35 and older or women at risk or personal risk factors
Rubella screen			Limited to once per lifetime	Limited to once per lifetime
Sexually transmitted disease screen			Once a year	Once a year
Serum lead screen	As needed			
Sickle cell anemia screen	As needed			
Thyroid screen	As needed			Once a year
Zoster/Shingles				Ages 60 and older

Review your medical plan Summary Plan Description for more detail on your plan benefits.

SANDIA NATIONAL LABORATORIES' DISCLOSURE OF MEDICARE PART D CREDITABLE COVERAGE NOTICE

Important Notice from Sandia National Laboratories About Your Prescription Drug Coverage and Medicare for 2009

This notice has information about your current prescription drug coverage with Sandia National Laboratories and prescription drug coverage available for people with Medicare. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage. **Please read this notice carefully and keep it where you can find it.**

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Sandia National Laboratories has determined that the prescription drug coverage offered by the UnitedHealthcare (UHC) Premier PPO, the UHC Standard PPO Plan, the CIGNA In-Network Plan, the Kaiser HMO, and the UHC Senior Premier PPO Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

   Note: If you enroll in the Presbyterian Medi-Care PPO Plan, the Lovelace Senior Plan or the Kaiser Permanente Senior Advantage Plan for 2009, you will automatically be enrolled in the new Medicare Part D prescription drug benefit through the Plan and will receive all of your prescription drugs through the plan you selected. This Notice does not apply to those enrolled in these Plans.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from November 15th through December 31st.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

WHAT HAPPENS TO YOUR CURRENT COVERAGE IF YOU DECIDE TO JOIN A MEDICARE DRUG PLAN?

Your current medical coverage through Sandia National Laboratories pays for other health expenses in addition to prescription drug. If you and/or your dependents enroll in a Medicare drug plan, you and/or your dependents will still be eligible to receive medical and prescription drug benefits. If you and/or your dependents enroll in a Medicare drug plan, in general, the following guidelines listed below apply. (Note: There are exceptions for Medicare domestic partners of employees as well as those plan participants who have End Stage Renal Disease. Please contact Sandia HBES at the number listed below for more information.)

If you are an active employee and are enrolled in the UnitedHealthcare (UHC) Premier PPO Plan, the UHC Standard PPO Plan, or the CIGNA In-Network Plan, you are required to obtain your outpatient prescription drug benefits through your Sandia plan first. You can then file on a secondary basis with your Medicare drug plan. Class II dependents of employees who are eligible for Medicare are required to obtain their outpatient prescription drugs through their Medicare drug plan first. Sandia coverage may pay on a secondary basis.

If you are a retiree, survivor, long-term disability terminee or COBRA participant and are enrolled in the UHC Senior Premier PPO Plan, you are required to obtain your outpatient prescription drugs through your Medicare drug plan first. You may file any non-covered expenses with the UHC Senior Premier PPO Plan for coverage on a secondary basis.

If you are an active employee and enroll in the Kaiser Permanente Traditional HMO, you are required to obtain your prescription drugs through your Sandia coverage first. You can file on a secondary basis with your Medicare drug plan.

> **Important**: You can only waive prescription drug coverage by waiving the entire medical plan coverage for yourself and your dependents. Remember, if you do waive your coverage, you can only re-enroll in the medical plan coverage during the next Open Enrollment Period.

WHEN WILL YOU PAY A HIGHER PREMIUM (PENALTY) TO JOIN A MEDICARE DRUG PLAN?

You should also know that if you drop or lose your coverage with Sandia National Laboratories and don't enroll in a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to enroll in a Medicare drug plan later.

If you go 63 days or longer without creditable prescription drug coverage, your monthly premium may go up at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to enroll.

FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE…

Contact the Sandia Health, Benefits, and Employee Services Customer Service Center

at 505-844-HBES (4237) or 800-417-2634, then 844-HBES for further information.

NOTE: You will receive this notice annually. You will also get it before the next period you can enroll in Medicare drug plan, and if this coverage through Sandia National Laboratories changes. You also may also request a copy of this notice at any time.

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans.

For more information about Medicare prescription drug plans:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit the Social Security Administration (SSA) on the web at www.socialsecurity.gov, or you can call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to enroll in one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: October 1, 2008
Name of Entity/Sender: Sandia National Laboratories
Contact – Position/Office: Benefits Department
Address: 1515 Eubank S.E.,
Albuquerque, NM 87123
Phone Number: 505-844-HBES (4237)

SPECIALTY DRUG MANAGEMENT PROGRAM: Drug List

Catalyst Rx's specialty drugs are those that may have the following characteristics: expensive, limited access, complicated treatment regimens, compliance issues, special storage requirements and/or manufacturer reporting requirements. Many medications listed below are biotech medications. Biotech products are manufactured using DNA recombinant technology (genetic replication) as opposed to chemical processes.

Listed below are drugs managed in the Catalyst Rx Specialty Drug Management Program. Most of the Catalyst Rx's specialty drugs are available through our preferred specialty vendor, Walgreens Specialty Pharmacy. Limited distribution drugs are only available through select specialty providers as determined by the drug manufacturer. Access to limited distribution drugs is available through other specialty providers in the Catalyst Rx's Specialty Drug Management Program.

*** Asterisk denotes products that can be administered in a physician's office and should not be restricted to pharmacy benefit coverage, e.g., blocked from medical billing.**

Drugs Available Through the Specialty Drug Management Program

Arthritis
ENBREL
EUFLEXXA*
HUMIRA
HYALGAN*
KINERET
ORTHOVISC*
REMICADE*
SUPARTZ*
SYNVISC*

Cardiovascular
REVATIO

Crohn's Disease
HUMIRA
REMICADE*

Enzyme Replacement
ALDURAZYME*
FABRAZYME*

Gaucher's Disease
CEREDASE*
CEREZYME*

Growth Hormone
GENOTROPIN
GENOTROPIN MINIQUICK
HUMATROPE
NORDITROPIN
NUTROPIN
NUTROPIN AQ
NUTROPIN DEPOT*
OMNITROPE
SAIZEN
SEROSTIM
TEV-TROPIN

Hematologics
ARANESP
ARIXTRA
EPOGEN
FRAGMIN
INNOHEP
LOVENOX
PROCRIT

Hemophilia
ADVATE*
ALPHANATE*
ALPHANINE SD*
BEBULIN VH*
BENEFIX*
FEIBA VH IMMUNO*
GENARC*
HELIXATE FS*
HEMOFIL-M*
HUMATE-P*
KOATE-DVI*
KOGENATE FS*
MONARC-M*
MONOCLATE-P*
MONONINE*
NOVOSEVEN*
PROFILNINE SD*
PROPLEX T*
RECOMBINATE*
REFACTO*

Hepatitis B
BAYGAM*
INTRON A
PEGASYS

Drugs Available Through the Specialty Drug Management Program cont.

Hepatitis C
ALFERON N*
COPEGUS
INFERGEN
INTRON A
PEGASYS
PEG-INTRON
REBETOL
REBETRON
ribasphere (generic)
ribavirin (generic)
ROFERON-A

HIV/AIDS
FUZEON

Immune Deficiency
BAYGAM*
BAYRHO-D*
CARIMUNE NF*
FLEBOGAMMA*
GAMMAGARD S/D*
GAMMAR-P I.V. *
GAMUNEX*
IMMUNE GLOBULIN*
IVEEGAM*
MICRHOGAM ULTRA-FILTRD*
OCTAGAM*
PANGLOBULIN*
POLYGAM S/D*
RHOGAM*
RHOPHYLAC*
VENOGLOBULIN-S*
WINRHO SDF*

Infertility
BRAVELLE
CETROTIDE
CHORIONIC GONADOTROPIN
FOLLISTIM
GANIRELIX ACETATE
GONAL-F/RFF
leuprolide acetate*(generic)
LUPRON*
LUVERIS
MENOPUR
NOVAREL
OVIDREL
PREGNYL
REPRONEX

Multiple Sclerosis
AVONEX
BETASERON
COPAXONE
NOVANTRONE*
REBIF

Oncology (Oral)
GLEEVEC
SPRYCEL
SUTENT
TARCEVA
TEMODAR
THALOMID
XELODA
ZOLINZA

Oncology and Related
ALOXI*
ANZEMET*
ELIGARD
KYTRIL*
LEUKINE*
leuprolide acetate* (generic)
LUPRON*
LUPRON DEPOT*
LUPRON DEPOT PED*
NEULASTA
NEUMEGA
NEUPOGEN
NOVANTRONE*
OCTREOTIDE
ondansetron (generic)
PROLEUKIN*
SANDOSTATIN
SANDOSTATIN LAR*
THYROGEN*
TRELSTAR LA/ DEPOT*
VIADUR*
ZOFRAN*
ZOLADEX*
ZOMETA*

Osteoporosis
FORTEO
RECLAST*

Psoriasis
AMEVIVE*
ENBREL
REMICADE*

Pulmonary Cystic Fibrosis
PULMOZYME
TOBI

RSV
RESPIGAM*

Ulcerative Colitis
REMICADE*

Miscellaneous
ACTIMMUNE
BOTOX
colistimethate (generic)*
COLY-MYCIN M*
MYOBLOC
SOLIRIS*
SUPPRELIN LA*
SYNAREL

Limited Distribution Drugs

( ) A representative specialty provider is noted in parenthesis for the respective drug. Additional specialty providers may be available.

Asthma
XOLAIR (Medmark/Walgreens)

Cardiovascular
FLOLAN* (Accredo)
Letairis (Medmark/Walgreens)
REMODULIN (Accredo)
TRACLEER (Accredo)
VENTAVIS (Accredo)

Enzyme Replacement
ELAPRASE* (Accredo)
NAGLAZYME* (Accredo)

Gaucher's Disease
ZAVESCA (Medmark/Walgreens)

Growth Hormone
INCRELEX (Curascript/Walgreens)
SOMAVERT (Express Scripts)
ZORBITIVE (Medmark/Walgreens)

Immune Globin
Vivaglobin (Medmark/Walgreens)

Oncology
IRESSA (Iressa Access Program)
NEXAVAR (Medmark/Walgreens)
REVLIMID (Medmark/Walgreens)
TYKERB (Medmark/Walgreens)
VANTAS* (Priority Healthcare)

Macular Degeneration
LUCENTIS* (Besse Medical/Walgreens)
MACUGEN* (Besse Medical/Walgreens)
VISUDYNE* (Besse Medical/Walgreens)

Multiple Sclerosis
ACTHAR HP (Medmark/Walgreens)
TYSABRI* (Medmark/Walgreens)

Narcolepsy
XYREM (Express Scripts)

Parkinson's Disease
APOKYN (Accredo)

Psoriasis
RAPTIVA (Medmark/Walgreens)

Renal Disease
CYSTAGON (PharmaCare)

Rheumatoid Arthritis
ORENCIA* (Medmark/Walgreens)

RSV
SYNAGIS* (Medmark/Walgreens)

Trypsin Deficiency
ARALAST* (Accredo)
PROLASTIN* (Express Scripts)
ZEMAIRA* (Accredo)

Specialty medications may require prior authorization to ensure appropriate usage. Coverage for these medications may vary with respect to benefit design.

This list is subject to change without notice to accommodate the introduction, removal and availability of new drugs and clinical information.

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Follow the instructions below to make changes to your 2009 medical coverage.

STEP 1: Are you making any changes to your medical coverage for next year?

☐ No	No action is necessary. DO NOT RETURN THIS FORM.
☐ Yes	Continue to Step 2

STEP 2: Do you need or want to change your medical plan for next year?

Note: CIGNA Premier/Senior Premier and High Deductible Health Plan are no longer medical plan options. All members enrolled in these plans MUST select another medical plan option.

☐ No
☐ Yes

NON-MEDICARE Member Plans		MEDICARE Member Plans	
☐	**UHC Premier PPO**	☐	**UHC Senior Premier PPO**
		☐	**Presbyterian MediCare PPO** (No corresponding non-Medicare Plan is available) Must be Medicare Part A & B eligible in January 2009 to enroll in this plan.
☐	**CIGNA In-Network**	☐	**Lovelace Senior Plan** Must be Medicare Part A & B eligible in January 2009 to enroll in this plan.
☐	**Kaiser Permanente Traditional HMO**	☐	**Kaiser Permanente Senior Advantage** Must be Medicare Part A & B eligible in January 2009 to enroll in this plan.

STEP 3: Do you want to add or drop dependents for medical or dental for next year?

☐ No	Continue to Step 4.
☐ Yes	Use the table below to add or drop your dependents

Add/ Drop	Name	Relationship	Birth Date/ Age	Medical	Dental
Add	*John Smith*	*Son*	*7/16/85 / 15*	*Yes*	*Yes*

STEP 4: Please print your name and phone number below

Name (print)	Age
Phone Number:	Social Security Number:

STEP 5: Sign & mail form in the envelope provided postmarked by November 10, 2008.

Signature	Date:

Benefits Choices 2009

OPEN ENROLLMENT

Sandia National Laboratories

Health Benefits Employee Services
HBE