2009 Benefits Choices

OPEN ENROLLMENT

Non-Represented Employee Newsletter 2009

OCTOBER 20 - NOVEMBER 10, 2008

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HR Self-Service—Web Enrollment Continues for Open Enrollment 2009

It's time again to make your benefit election decisions for the coming calendar year. The web enrollment system will be available from October 20 through November 10. Benefit elections will not be accepted after 5:00 pm (MST), November 10. All benefit elections take effect January 1, 2009. Employees can locate the web enrollment tool through HR Self-Service on the internal web page. It is your responsibility to thoroughly review your benefit enrollments for 2009 through the web-page "PeopleSoft Open Enrollment" between October 20 through November 10. This will be your only opportunity to make changes.

Important: A cryptocard is required if you want to make your elections from a remote location or home.

Spouse/Employee Fair

Thursday, October 23,
1:00 pm – 2:00 pm
Winrock Theatre, 201 Winrock Center in Albuquerque

benefit fairs for 2009

Albuquerque

October 22 — *10 am - 2 pm, Steve Schiff Auditorium, Bldg. 825*

October 29 — *10 am - 2 pm, Steve Schiff Auditorium Bldg. 825*

November 4 — *10 am - 2 pm, Steve Schiff Auditorium Bldg. 825*

Livermore

October 27 — *10 am - 2 pm (Pacific Time) Bldg. 904/905 Mezzanine*

Presentation Agenda

11:00 am -11:30 am
Medical Plan Benefit Changes Overview

11:30 am – 12:00 pm
New Dental Care Plan

12:00 pm -12:30 pm
Long-Term Disability Plus Plan

12:30 pm -1:30 pm
Flexible Spending Accounts (formerly referred to as Reimbursement Spending Accounts)

What's changing for me in 2009?

- **CIGNA Premier PPO Plan is being eliminated** as a plan choice
- CIGNA In-Network Plan; the administrator for your **prescription drug benefit is changing from CIGNA to Catalyst Rx**; the prescription drug benefits will mirror those of the UnitedHealthcare plans
- **Specialty drugs must be purchased through Catalyst Rx Drug Management Program for UHC and CIGNA members** and specialty drugs will be limited to a 30 day supply at the retail coinsurance/copay level of benefits
- **UHC, CIGNA and Kaiser plans** have design changes (e.g. copay increases)
- **New Mexico On-site Pharmacy** located in Building 832 to open soon
- **New Dental Care Plan** (with premium share), which replaces the current Dental Expense/Deluxe plans
- Employee premium-sharing will increase to 19% overall and will move from a **three tier to four tier salary premium share** structure
- Class I and Class II eligibility policy for health care plans has been modified
- **Health Care Flexible Spending Account** (formerly known as a Health Care Reimbursement Spending Account) maximum allowed is **increasing**
- Special **Long-Term Disability Plus enrollment bypassing evidence of insurability** requirement, this year only!
- Important change to Student Intern medical coverage

WHAT CLASS I AND CLASS II ELIGIBILITY POLICY HAS BEEN CHANGED?

Class I Dependents

- child definition has been modified to remove the financial dependency requirement for unmarried child age 19 through age 23
- unmarried stepchild definition has been changed from stepchild living with the primary insured (stepchildren visiting for the summer are not considered to be living with you) to unmarried stepchild of the primary covered member who live with you at least 50% of the calendar year, or if ages 19 through 23 are a full time student

Class II Dependents

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.

All enrolled primary members are responsible for determining if their dependents meet the eligibility requirements of Sandia's health plans. This is very important as Sandia reserves the right to conduct dependent eligibility audits to ensure an enrolled dependent is eligible for coverage under the terms of the plans.

The consequences of having an ineligible dependent covered and failing to disenroll a dependent within the allowed time frame are significant; they include:

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ENROLLING ELIGIBLE DEPENDENTS

You can add eligible dependents to your medical plan when you first enroll in the plan or during the annual Open Enrollment period. You can enroll dependents during the plan year ONLY when you experience a qualified life event, such as marriage, birth or loss of other coverage, that allows enrollment in the plan. Please refer to the Pre-Tax Premium Plan booklet for qualifying Mid-Year Election Change Events. The change must be made within 31 calendar days of the event or you will have to wait until the next annual Open Enrollment period to add your dependent.

DISENROLLING INELIGIBLE DEPENDENTS

You can also disenroll dependents during the Open Enrollment period. During the year, if your dependent becomes ineligible for any reason, you must disenroll your ineligible dependent within 31 calendar days of the dependent becoming ineligible.

Announcing the new on-site pharmacy!

That's right; employees will have access to an On-site Pharmacy with a dedicated pharmacist to answer those important pharmacy questions. A New Mexico On-site Pharmacy located in Building 832 will be available to all non-represented employees and their dependents enrolled in the UHC Standard and Premier PPO Plans, and CIGNA In-Network Plan. In addition to dispensing brand name drugs in 30 or 90 day increments, the pharmacy will provide discounted generic drugs for $4 (30-day supply) or $12 (90-day supply), over the counter drug purchases and convenience. You now have three options for finding the best price on your prescription drugs – a retail pharmacy, mail order pharmacy, and the on-site pharmacy. Look for details on the grand opening.

Important Change for Student Interns!

Summer student interns will no longer be eligible for medical plan coverage. Year round student interns will be limited to the UHC Standard PPO Plan medical coverage. Student Interns currently in the UHC Premier PPO, CIGNA Premier PPO, CIGNA In-Network or Kaiser plans, must select the UHC Standard PPO Plan during Open Enrollment to have medical coverage in calendar year 2009.

- Your ineligible dependent's coverage will be retroactively terminated, effective the end of the month in which the dependent became ineligible
- You will be held liable to refund to Sandia for all health care plan claims or monthly premiums rendered during the ineligible period
- Sandia is not liable to repay you for any health care plan monthly premium share(s) paid by you during the ineligible period
- Sandia may take employment disciplinary action up to and including termination
- Your dependent could lose any rights to temporary, continued health care coverage under COBRA

Important: Employees are required to determine if their dependent qualifies as a qualified dependent under Internal Revenue Code Section 152 guidelines **(see IRS Publication 502 for more information)** for the purpose of health

care coverage. If your dependent is not a qualified dependent under the tax code, you are required to contact the Benefits Department to determine whether any imputed income may apply for that non-qualified dependent. Please refer to the Open Enrollment website, Dependent Eligibility Info, for more information.

Finally, the dental plan employees have been wanting for years.

Employees will have a new Dental Care Plan, which replaces the current Dental Expense/Deluxe plans. The Dental Care Plan will be a coinsurance plan replacing the schedule type benefit plans offered today.

Expenses, other than preventive and orthodontic, will incur a $50 individual annual deductible (with a $150 family maximum). The annual maximum for all expenses is $1,500 per person. The lifetime orthodontic maximum is $1,800 per person. Sealants for children under 14 will be covered under the preventive benefit. Employees will pay a monthly premium share, on a pre-tax basis, for the new plan.

The DCP will reimburse care as follows:

	Delta Dental PPO Reimbursed as a % of the Maximum Approved Fees applicable to Delta Dental PPO Network	**Delta Dental Premier** Reimbursed as a % of the Maximum Approved Fees applicable to Delta Dental Premier	**Out-of-Network** Reimbursed as a % of the Maximum Approved Fees applicable to Delta Dental Premier (balance billing protections do not apply)
Preventive Care	100%	100%	100%
Basic and Restorative	80%	80%	80%
Major and Orthodontic (including specified types of implants)	50%	50%	50%

Dental Care Plan Monthly Premiums

Employee only	$8
Employee plus one	$15
Employee plus two	$20

Vision Care Plan

Have annual optical needs? Save some dollars by using the Sandia Vision Care Plan. The Vision Care Plan is the company-paid vision plan. The Vision Plan is a basic benefit designed to encourage regular eye examinations, assist with the expenses for needed eyeglass frames and corrective lenses, and help offset the cost of additional eyewear purchases through a network provider. Currently, the Vision Plan is administered by Davis Vision.

Plan Changes Effective January 1, 2009— None

IMPORTANT!

You and your dependents currently enrolled in both the Dental Expense and Dental Deluxe Plans will be automatically enrolled in the NEW Dental Care Plan. **Employees who do not want this plan must waive coverage** during the Open Enrollment period.

Your Next Steps

Benefit Options	Take Action via HR-Self Service	No Action Required
Medical Coverage	» To enroll in a new medical plan if you are currently in the CIGNA Premier PPO Plan » To enroll if not currently enrolled » To change your current medical plan » To add or disenroll a dependant » To waive coverage	» No change if you are currently enrolled in the UHC Premier PPO, UHC Standard PPO, CIGNA In-network or Kaiser plans
NEW! Dental Coverage (requires payroll deduction)	» To **waive coverage** if you do not want the Dental Care Plan in 2009. » To add or disenroll a dependent » To enroll if not currently enrolled	» To be enrolled in the Dental Care Plan if you are currently enrolled in the Dental Expense/Deluxe Plans
Vision Care Plan Coverage	» To enroll if not currently enrolled » To add or disenroll a dependent » To waive coverage	» No change in your current vision coverage
Flexible Spending Accounts (FSA) formerly Reimbursement Spending Accounts	» To enroll in a Health Care FSA for 2009 (even if you participated in 2008) » To enroll in a Day Care FSA for 2009 (even if you participated in 2008)	» To not be enrolled for 2009
Vacation Buy Plan	» To enroll for 2009 (even if you participated in 2008)	» To not be enrolled for 2009
Voluntary Group Accident Insurance	» To enroll, disenroll or change coverage	» No change in your Voluntary Group Accident Insurance Coverage
Long-Term Disability Plus Plan ONE TIME ONLY OPPORTUNITY TO INCREASE COVERAGE WITHOUT EVIDENCE OF INSURABILITY	» To increase or decrease current coverage (additional 10% or 20% coverage)	» No change in your Long-Term Disability Plan coverage

Are you considering retirement soon?

Employees that retire after December 31, 2008, will be required to pay the same Dental Care Plan premium share as employees. Employees that retire before January 1, 2009 will receive the Dental Care Plan benefit but will not have a monthly cost at this time. Employees that are hired or rehired and retire after December 31, 2008, will be required to pay the full premium cost for the Dental Care Plan.

Primary Group Term Life Insurance provided to retirees is changing effective 1/1/2009. Employees retiring on or before 12/31/2008 will receive a Primary Group Term Life Insurance benefit equal to one times their annual base pay. Employees retiring after 12/31/2008 will receive a Primary Group Term Life Insurance benefit equal to the lesser of 1) one times their annual base pay, or, 2) $50,000. Coverage decreases by 10% per year for five years beginning at age 66. Benefits after age 70 are equal to 50% of the original coverage amount. Employees hired after 12/31/2006 are not eligible for post-retirement Primary Group Term Life insurance benefits.

VACATION BUY PLAN

Need work/life balance? – Buy some extra time in 2009! Sandia's Vacation Buy Plan (VBP) allows participants to purchase vacation on a pre-tax basis. By participating in VBP, employees can spread out the financial impact of purchasing additional paid time off over the course of a calendar year.

All regular employees, Post-docs, and Limited Term Employees, are eligible to participate in VBP. Eligible employees may purchase between 8 and 44 hours, deducted evenly from biweekly paychecks throughout the calendar year. Any unused bought vacation is sold back in the last paycheck in December at the same rate as purchased. This program requires re-enrollment every year.

VOLUNTARY GROUP ACCIDENT PLAN

Is your family protected? An accident insurance plan you may want to consider. Voluntary Group Accident Insurance (VGA) is accident insurance that you may purchase for a monthly premium rate. Coverage is available in amounts ranging from $10,000 to $300,000, in units of $5,000 (maximum $300,000 combined total among three plan options). The three plan options are as follows: employee only, family plan, and employee-only common carrier coverage. Look here to find out more about VGA plan details, costs, and enrollment instructions.

FLEXIBLE SPENDING ACCOUNTS(FSA)

formerly Reimbursement Spending Accounts

HEALTHCARE FLEXIBLE SPENDING ACCOUNT (HCFSA) allows you to set aside pre-tax dollars to pay for eligible medical, dental, and vision expenses that are not reimbursed under your health benefits plan. Examples of eligible expenses are: deductibles, coinsurance, copayments for doctors' visits and prescription drugs, certain over-the-counter drug expenses and dental fees.

2009 Plan Changes – The maximum annual contribution increased from $4,000 to $5,000 per plan year.

DAY CARE FLEXIBLE SPENDING ACCOUNT (DCFSA) allows you to set aside money to pay for the care of a dependent child before the money is taxed as income. Eligible dependent care expenses include: day care facility and local day camp fees for qualified dependents, and baby-sitting fees for at-home care of qualified dependents while you and your spouse are working. If you are married, you and your spouse are limited to $5,000 annually if you file a joint tax return, or to $2,500 each if you file separate returns.

2009 Plan Changes – None

IMPORTANT!

Health Care Flexible Spending Account (formerly known as a Heath Care Reimbursement Spending Account) maximum allowed is increasing.

So why hassle with a Flexible Spending Account (FSA)?

The advantage of using FSAs is that you do not pay federal income or Social Security tax on the money in these accounts. In most states, you don't need to pay state taxes on this money either.

Thus, by paying your out-of-pocket healthcare expenses and daycare expenses through the FSAs, you can lower your taxes. You add dollars to your net income, which means that you have more take home pay and more money in your pocket! Essentially you can give yourself a raise.

You must enroll during Open Enrollment to participate in calendar year 2009, even if you participated in an FSA account in 2008.

Click here for more information about FSAs.

LONG-TERM DISABILITY PLUS SPECIAL ENROLLMENT

Special Long-Term Disability Plus enrollment bypassing evidence of insurability, this year only!

Effective January 1, 2009, the benefit under the employee Sickness Absence Plan (short-term disability) is being reduced from 2080 hours to 1040 hours at full pay, and the Disability Retirement benefit currently under the Retirement Income Plan will no longer be a benefit for employees. Because of this change, employees have an opportunity to enroll in the employee paid Long-Term Disability Plus Plan, without evidence of insurability, during the 2009 Open Enrollment period (this year only).

Why should I consider purchasing additional Long-Term Disability (LTD) insurance? LTD Plus insurance provides additional salary protection if you become disabled according to the terms of the plan. LTD takes over after you have exhausted your Sickness Absence Plan (short-term disability) benefit. The supplemental buy-up LTD benefit goes in effect the day following the completion of 12 months of premium payment. Click here to find out more about the LTD and LTD Plus Plans.

SELECTING A MEDICAL PLAN

What to consider when choosing the medical plan that's right for you.

YOU MAY WANT TO CONSIDER THE FOLLOWING WHEN CHOOSING A MEDICAL PLAN:

PROVIDER NETWORKS

How far are you willing to travel to see a network provider? In NM, do you use Lovelace or Presbyterian doctors? Do you use facilities outside of NM? Do you use centers of excellence and which one is in-network?

BENEFIT COVERAGE

Does the plan cover what you need (e.g. infertility, acupuncture, behavioral health)? Are there any benefit limitations on the service(s) you will need?

IN- AND OUT-OF-NETWORK COVERAGE

Do you want flexibility to go outside of the network? The PPO plans offer employees the ability to seek care both in- and out-of-network. Seeking services out-of-network does come with a higher price tag as you have to meet a modest deductible (for Premier PPO plan) and a significant deductible (for UHC Standard PPO Plan). Co-insurance is at the highest level with Sandia covering 70% of usual and customary and anything charged above the usual and customary also comes out of your pocket. In addition, your out of pocket maximum is higher.

COPAY VS. COINSURANCE

Do you want a plan that is set up primarily with copays offering a fixed payment when you seek services? Are you comfortable with a plan that is set up with co-insurance payments where you are responsible for a percentage of the cost for service?

COVERAGE WHILE ON TRAVEL

When my family is on travel within the United States or on international travel, how will the plan cover emergency, urgent care or follow-up care?

DEPENDENT COVERAGE

How does the Plan cover my children away at college? Since the CIGNA In-Network and Kaiser HMO Plans only offer in-network benefits, enrolling in a PPO with both in- and out-of-network benefits may be more beneficial.

MONTHLY PREMIUM SHARE

How much will a particular plan cost per month?

CONSUMER TOOLS

How can I become a better health care consumer? Sandia provides a number of tools (described below) to assist employees with the process of evaluating the differences in the plans offered.

HEALTH PLAN WEBSITE AND NETWORK DIRECTORIES:

Employees can use the health plan's physician/facility directories to locate current in-network providers.

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MEDICAL PLANS AT A GLANCE

Employees currently in the CIGNA Premier PPO Plan must select a new plan during Open Enrollment to have medical coverage in calendar year 2009.

	UnitedHealthcare Premier PPO	UnitedHealthcare Standard PPO	CIGNA In-Network	Kaiser HMO California Only
Type of Plan	Preferred Provider Organization (PPO)	Preferred Provider Organization (PPO)	Exclusive Provider Organization (HMO Look-Alike)	Health Maintenance Organization (HMO)
Provider Network in New Mexico	Presbyterian UNMH Independent Providers	Presbyterian UNMH Independent Providers	Lovelace Health System UNMH Independent Providers	Not Applicable
In/Out Network Coverage	Both	Both	In-Network Only	In-Network Only
Referrals to Specialist Required	No	No	No	Some Services
Plan Design	Primarily Co-insurance	Primarily Co-insurance	Primarily Co-Pays	Co-Pays
	Out of Network Deductible	In and Out of Network Deductible	No deductible	No deductible
Prescription Drug Program Administrator	Catalyst Rx	Catalyst Rx	Catalyst Rx	Kaiser

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It is important to make sure that the physicians and facilities you and your family use are in the plan network you are considering. In-network verification that physicians and facilities are still in your health plan network should occur throughout the year.

Employees can also use the health plan's website to find out about important additional resources, benefits and specialty networks available under each plan.

MEDICAL PLAN ESTIMATOR TOOL:

Employees can use the Medical Plan Estimator Tool (available on Sandia's Employee Open Enrollment website) to compare the plans' costs against each other. You simply enter your salary tier information, family coverage level and the services anticipated for yourself and your family members during the following calendar year. The tool will calculate an estimate of the total plan cost across all plans offered. The tool gives you a picture of what you are likely to pay for services, supplies and annual cost of the monthly premium share over the course of the year.

MEDICAL PLANS COMPARISON CHART:

You can use the Employee Medical Plan Comparison Chart (which will be mailed to your mail stop) to compare plan designs (copay, coinsurance, etc.) and other limitations or restrictions identified for each plan.

Note: For more descriptive plan coverage details, review the plan Summary Plan Description located on Sandia's external web.

MONTHLY PREMIUM SHARE TABLE:

Use the monthly premium share table to evaluate the monthly cost of each plan. The table will show what your monthly premium share will be according to your salary tier and level of coverage for employee.

OPEN ENROLLMENT BENEFITS FAIRS:

Visit an Open Enrollment Benefits Fair to ask questions of the specific plan vendors.

MEDICAL PLAN CHANGES >> EFFECTIVE JANUARY 1, 2009

CIGNA Premier PPO Plan is being eliminated as a plan choice:

Employees currently enrolled in this plan should carefully evaluate the medical plan options offered. Employees must select another medical plan option during Open Enrollment to have coverage in Calendar Year 2009.

CIGNA In-Network Plan Changes:

- CIGNA members will see a change in administrator for prescription drug benefit from CIGNA to Catalyst Rx. CIGNA members' prescriptions drug benefits will mirror the UHC plans prescription drug benefit. It is important to take time to evaluate and understand how the new Catalyst Rx drug formulary and the prescription coinsurance structure will impact the drugs you purchase. To find out if your prescription drug is preferred or not, call Catalyst Rx at (866) 854-8851. Also, 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!
- 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

CIGNA In-Network Pharmacy Benefit Changes 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 $80 minimum and $120 maximum

Other

- On-Site Pharmacy benefit level – you can receive up to a 30 day supply or up to a 90 day supply at the retail/mail order copay/coinsurance for preferred and non-preferred brand; generic prescriptions will cost $4 for up to a 30 day supply and $12 for up to a 90 day supply
- New Mandatory Specialty Drug Program (for more information see page 11 for article)

UnitedHealthCare (UHC) Premier PPO Changes:

- Office Visit Copay – Primary Care Physician from $15 to $20 copay
- Office Visit Copay – Specialist from $25 to $35 copay
- Allergy Treatment from $25 copay to 15% of negotiated fees
- 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.

UnitedHealthCare (UHC) Standard PPO Changes:

- Office Visit Copay – Primary Care Physician from $15 to $20 copay
- Office Visit Copay – Specialist from $25 to $35 copay
- Allergy Treatment from $25 copay to 20% of negotiated fees (after the deductible)
- Chiropractic – from combined Acupuncture/ Chiropractic benefit to a separate calendar year $500 maximum combined in- and out-of-network
- Acupuncture – from combined Acupuncture/ Chiropractic benefit to a separate calendar year $500 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.

UnitedHealthCare (UHC) Premier and Standard Pharmacy Benefit Changes:

- Mail Order Generic – from $18 copay to 20% of mail order price with $12 minimum and $24 maximum
- Mail Order Preferred Brand – from $65 copay to 30% of mail order price with $50 minimum and $80 maximum
- Mail Order Non Preferred Brand – from $100 copay to 40% of mail order price with $80 minimum and $120 maximum
- On-Site Pharmacy benefit level – you can receive up to a 30 day supply or up to a 90 day supply at the retail/mail order copay/coinsurance for preferred and non-preferred brand; generic prescriptions will cost $4 for up to a 30 day supply and $12 for up to a 90 day supply
- New Mandatory Specialty Drug Program (for more information see article this page)

Kaiser HMO (CA Only) Plan Changes:

- 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 Changes:

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

New mandatory specialty drug benefit administered by Catalyst Rx for UHC and CIGNA members

Employees enrolled in the UHC Standard and UHC Premier PPO plans and CIGNA In-Network plan, who are taking a specialty medication, must purchase them through the Catalyst Rx Specialty Drug Management Program.

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".

MONTHLY PREMIUM-SHARE AMOUNTS NONREPRESENTED EMPLOYEES

Non-represented employees will move from a three tier to four tier salary premium share structure. Salary Tier 1 up to $50,000, Tier 2 from $50,001 to $80,000, Tier 3 from $80,001 to $130,000 and Tier 4 base salary $130,001 or above, as of January 1, 2009. Overall employee premium-sharing will also increase from 18 to 19% in 2009.

The table below provides the monthly premium-share amounts for non-represented employees for each of the plans. Premiums are taken on a pretax basis.

Medical Plan & Coverage	Tier 1*	Tier 2**	Tier 3†	Tier 4††
UnitedHealthcare Standard PPO Plan				
Employee only	$6	$11	$28	$45
Employee and child(ren)	$14	$23	$53	$84
Employee and spouse	$14	$24	$59	$94
Employee, spouse, and child(ren)	$21	$36	$85	$134
UnitedHealthcare Premier PPO Plan				
Employee only	$65	$70	$87	$104
Employee and child(ren)	$120	$129	$159	$190
Employee and spouse	$135	$145	$180	$215
Employee, spouse, and child(ren)	$192	$207	$256	$305

Medical Plan & Coverage	Tier 1*	Tier 2**	Tier 3†	Tier 4††
CIGNA In-Network plan				
Employee only	$69	$74	$91	$108
Employee and child(ren)	$127	$136	$166	$197
Employee and spouse	$143	$153	$188	$223
Employee, spouse, and child(ren)	$204	$219	$268	$317
Kaiser Permanente HMO plan (CA)				
Employee only	$69	$74	$91	$108
Employee and child(ren)	$127	$136	$166	$197
Employee and spouse	$143	$153	$188	$223
Employee, spouse, and child(ren)	$204	$219	$268	$317

* Tier 1: Base salary of up to $50,000 as of January 1, 2009
** Tier 2: Base salary of $50,001 to $80,000 as of January 1, 2009
† Tier 3: Base salary of $80,001 to $130,000 as of January 1, 2009
†† Tier 4: Base salary of $130,001 or above as of January 1, 2009

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.

Health Insurance & Portability Accountability Act of 1996

GOT QUESTIONS?

Health, Benefits, and Employee Services (NM)

Ask a Question at http://hbe.sandia.gov

Customer Service: (505) 844-HBES (4237)

or (800) 417-2634, ext. 844-HBES (4237)

Click here to get a comprehensive list of important Benefit Contacts.

Disclosure of Creditable Coverage to Medicare Part D Eligible Individuals

Each year, Sandia is required to provide a "Notice of Creditable Coverage" to all members enrolled in self-insured medical plans to explain how the prescription-drug coverage provided by their medical plans compares to Medicare's prescription-drug coverage. This notice, sent with the email containing this newsletter, has information about current prescription-drug coverage under the self-insured medical plans and prescription-drug coverage available for people with Medicare. You are encouraged to read this notice to understand any implications that may apply to you and/or your covered dependents.

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.