

Benefits Choices 2008



OPEN ENROLLMENT

Retirees
Survivors
LTD Terminees

*Annual Open Enrollment
October 20 - November 9, 2007*



Welcome to Open Enrollment Benefits Choices 2008

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.

Sandia's Open Enrollment period for Benefits Choices 2008 will run from October 20 to November 9, 2007.

All enrollment changes (including to add/drop a dependent) require completion of the Open Enrollment Change Form included in this packet. The Open Enrollment Change Form must be postmarked on or before November 9, 2007. All benefit changes take effect January 1, 2008, for the 2008 calendar year.

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

Important

- All changes must be mailed and postmarked by November 9, 2007 or they will not be accepted.
- If you have no changes, you do not need to complete the Open Enrollment Form.



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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.

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, 2008:
New Pharmacy Vendor – Catalyst Rx

Highlights:

- Refer to the Medical Plans Comparison Chart for an overview of benefits of this plan.
- This Plan gives members referral-free access to UHC's nationwide network of providers.
- Certain in-network preventive care is covered at 100% before the deductible is met.
- Infertility benefits and employee assistance program benefits are not covered.
- Both in- and out-of-network coverage is available, although members receive a

greater benefit when they receive care from an in-network provider.

- In addition to access to network providers, this Plan provides access to premium networks for transplants and cancer services.
- Outpatient prescription drug coverage is provided through Catalyst Rx.
- Coverage is available worldwide for emergency and urgent care. Follow-up care while on travel is covered at the in-network level of benefit if you are outside of the United States or not located within 30 miles of an in-network provider within the United States.
- Copayments that you pay to see a physician do not apply to the annual deductible or the out-of-pocket maximums.
- Co-insurance (indicated as a percentage) is the amount the patient pays after meeting the deductible, and is based on either the negotiated fees (in-network) or eligible expenses (out-of-network). Coinsurance amounts apply to the deductible and to the out-of-pocket maximums.
- 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 United Behavioral Health (UBH) network of providers.

Guidelines:

- Prior notification to UHC is required for certain medical services, procedures, and hospitalizations.
- Precertification to UBH is required before you receive certain behavioral health services.
- Members are responsible for the first \$300 of covered charges for failure to follow notification and/or precertification procedures.

Member Resources:

UnitedHealthcare offers the following member resources to aid members in managing their own care and achieving better health.

- Access to a 24-hour nurse advice line (Optum NurseLine) is available at 1-800-563-0416. Access to a voluntary disease management program for coronary artery disease, diabetes, congestive heart failure, and asthma.
- Access to health information and convenient self-service tools is available at www.myuhc.com and allows you to:
 - Research a health condition and treatment options to get ready for a discussion with your physician
 - Access wellness topics from Optum Nurse-Line including Live Nurse Chat 24 hours a day, seven days a week
 - Access a health risk assessment to identify health habits you can improve, learn about healthful lifestyle techniques, and access health improvement resources
 - Access a treatment cost estimator to obtain an estimate of the costs of various procedures in your area
 - Access a hospital comparison tool to compare hospitals in your area on

various patient safety and quality measures

- Make real-time inquiries into the status and history of your claims
- View eligibility and plan benefit information
- View and print all of your Explanation of Benefits (EOB) online
- Order a new or replacement ID card or print a temporary ID card

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 Medical Plans Comparison Chart and/or attend a Benefits Choices 2008 presentation (a schedule of presentations will be printed in the September 27th edition of the Lab News).

The Prescription Drug Program (PDP) is administered by Catalyst Rx. The PDP consists of a Mail-Order Program to obtain maintenance prescriptions and retail network and out-of-network pharmacies to obtain short-term medications. You may use any licensed physician to obtain your prescription.

Prescription Drug Program Key Points

Eligibility:

Members eligible for coverage under the UnitedHealthcare (UHC) Premier PPO Plan are eligible for the Prescription Drug Program. 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 and/or your covered dependents enrolled in a Medicare Part D prescription drug plan for 2008, refer to the Creditable Coverage Disclosure Notice for 2008 (mailed to you in September) for information on how this may impact your prescription drug coverage through Sandia.

Highlights:

- Refer to the Medical Plans Comparison Chart for an overview of the prescription drug benefits for this plan.
- Although the copay structure for 2008 is not changing, *it is important to note that Catalyst Rx has its own preferred drug list, therefore, the cost for one or more of your prescription drugs could change due to a change in the preferred/non-preferred status of the drug.*
- The majority (99%) of the retail network pharmacies that you regularly accessed under PharmaCare will continue to be a part

of the network with Catalyst Rx.

- Details of the transition of mail order refills currently under PharmaCare to Catalyst Rx, and other important information, will be provided via communications to your home over the next couple of months, so watch for them!
- **Catalyst Rx “welcome kits” containing your new identification cards, mail order forms and envelope, an abbreviated preferred brand-name drug list, as well as other important information will be mailed to home addresses in December.**
- Resources (available beginning October 20th) to assist you with the transition include:
 - www.catalystrx.com (user id and password is SNL)
 - Catalyst Rx customer service representatives at 866-854-8851
 - Sandia external website (UHC Rx Info) – <http://www.sandia.gov/resources/emp-ret/spd/rxinfo.html>
 - Sandia’s HBE Customer Service at 505-844-4237

Guidelines:

- 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.
- Your prescription benefits can now be accessed at over 59,000 retail pharmacies nationwide, including Walgreens, CVS, and Kmart. For a complete list of participating pharmacies please visit www.catalystrx.com.
- 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).

- Copayments and/or coinsurance do not apply to the UHC Premier PPO Plan deductibles or 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 1-866-854-8851.
- To receive a list of the preferred drugs, go to www.catalystrx.com or call Catalyst Rx at 1-866-854-8851.
- Introduction of a new drug to the market does not guarantee coverage of that drug under the PDP.

Important for New Enrollees in the UHC Premier PPO Plan

Pharmacy implementation kits containing identification cards, mail-order forms and envelopes, and a preferred brand-name drug list will be mailed to home addresses in December. This is in addition to your UHC medical ID card.

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

The UnitedHealthcare (UHC) Senior Premier PPO Plan is administered by United HealthCare. 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.

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 or the UHC High Deductible Health Plan.

Plan Changes Effective January 1, 2008:
New Pharmacy Vendor – Catalyst Rx

Highlights:

- Refer to the Medical Plans Comparison Chart for an overview of the benefits of this Plan.
- This Plan provides members with referral-free access to UHC's nationwide network of providers.
- Certain in-network preventive care is covered at 100%.
- 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.

- Infertility benefits and employee assistance program benefits are not covered.
- Both in- and out-of-network coverage is available.
- In addition to access to network providers, this Plan provides access to premium networks for transplants and cancer services.
- Outpatient prescription drug coverage is provided through Catalyst Rx.
- Coverage is available worldwide for emergency and urgent care. Follow-up care while you are on travel is covered at the in-network level of benefit if you are outside of the United States or not located within 30 miles of an in-network provider within the United States.
- Co-insurance (indicated as a percentage) is the amount the patient pays and is based on either the negotiated fees (in-network) or eligible expenses (out-of-network). Coinsurance amounts apply to the out-of-pocket maximums.
- 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 United Behavioral Health (UBH) 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.

Guidelines:

Members in this 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.

Member Resources:

UnitedHealthcare offers the following member resources to aid members in managing their own care and achieving better health.

- Access to a 24-hour nurse advice line (Optum NurseLine) is available at 1-877-835-9855.
- Access to a voluntary disease management program for coronary artery disease, diabetes, congestive heart failure, and asthma.
- Access to health information and convenient self-service tools is available at www.myuhc.com and allows you to:
 - o Research a health condition and treatment options to get ready for a discussion with your physician
 - o Access wellness topics from Optum NurseLine including Live Nurse Chat 24 hours a day, seven days a week
 - o Access a health risk assessment to identify health habits you can improve, learn about healthful lifestyle techniques, and access health improvement resources
 - o Access a treatment cost estimator to obtain an estimate of the costs of various procedures in your area
 - o Access a hospital comparison tool to compare hospitals in your area on various patient safety and quality measures
 - o Make real-time inquiries into the status and history of your claims
 - o View eligibility and plan benefit information

- o View and print all of your Explanation of Benefits (EOBs) online
- o Order a new or replacement ID card or print a temporary ID card

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 Medical Plans Comparison Chart and/or attend a Benefits Choices 2008 presentation (a schedule of presentations will be printed in the September 27th edition of the Lab News).

The Prescription Drug Program (PDP) is administered by Catalyst Rx. The PDP consists of a Mail-Order Program to obtain maintenance prescriptions and retail network and out-of-network pharmacies to obtain short-term medications. You may use any licensed physician to obtain your prescription.

Prescription Drug Program Key Points

Eligibility:

Members eligible for coverage under the UnitedHealthcare (UHC) Senior Premier PPO Plan are eligible for the Prescription Drug Program. 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 and/or your covered dependents enrolled in a Medicare Part D prescription drug plan for 2008, refer to the Creditable Coverage Disclosure Notice for

2008 for information on how this may impact your prescription drug coverage through Sandia.

Highlights:

- Refer to the Medical Plans Comparison Chart for an overview of the prescription drug benefits.
- You are not required to enroll in Medicare Part D if participating in this Plan.
- If you and/or your dependents enroll in a Medicare prescription drug plan, you and your dependents will still be eligible to receive all of your current medical and prescription drug benefits. The prescription drug benefits you receive through the Medicare prescription drug plan will be coordinated with the prescription drug coverage you have with Sandia National Laboratories according to federal law. You are required to use your Medicare prescription drug plan prior to submitting any claims for coordination of benefits with Catalyst Rx.
- Although the copay structure for 2008 is not changing, *it is important to note that Catalyst Rx has its own preferred drug list, therefore, the cost for one or more of your prescription drugs could change due to a change in the preferred/non-preferred status of the drug.*
- The majority (99%) of the retail network pharmacies that you regularly accessed under PharmaCare will continue to be a part of the network with Catalyst Rx.
- *Details of the transition of mail order refills currently under PharmaCare to Catalyst Rx, and other important information, will be provided via communications to your home over the next couple of months, so watch for them!*

- *Catalyst Rx “welcome kits” containing your new identification cards, a mail order form and envelope, an abbreviated preferred brand-name drug list, as well as other important information will be mailed to home addresses in December.*
- *Resources (available beginning October 20th) to assist you with the transition include:*
 - www.catalystrx.com (user id and password is SNL)
 - Catalyst Rx customer service representatives at 866-854-8851
 - Sandia external website (UHC Rx Info) – <http://www.sandia.gov/resources/emp-ret/spd/rxinfo.html>
 - Sandia’s HBE Customer Service at 505-844-4237

Guidelines:

- You must show your Catalyst identification card to obtain the applicable copayment at a retail network pharmacy. If you do not show your Catalyst 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).
- Copayments and/or coinsurance do not apply to the Senior Premier 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 at 1-866-854-8851.
- To receive a list of the preferred drugs, go

to www.catalystrx.com or call Catalyst at 1-866-854-8851.

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

Important For New Enrollees in the UHC Senior Premier PPO Plan:

Pharmacy implementation kits containing identification cards, mail-order forms and envelopes, a preferred brand-name drug list, as well as other important information will be mailed to home addresses in December. This is in addition to your UHC medical ID card.



UNITEDHEALTHCARE HIGH DEDUCTIBLE HEALTH PLAN (HDHP)

The UnitedHealthcare (UHC) High Deductible Health Plan (HDHP) is administered by UnitedHealthcare. This Plan is compatible with Health Savings Accounts (HSAs). In addition, this Plan allows members to see any licensed provider, although benefits are greater when care is received from a UHC network provider.

High Deductible Health Plan (HDHP) Key Points

Eligibility:

This Plan is available to non-Medicare retirees, survivors, LTD terminees and their eligible non-Medicare Class I and Class II dependents.

Note: If your dependent(s) are Medicare-primary and you enroll in this Plan, you can enroll your dependent(s) 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, 2008: None

Highlights:

- Refer to the Medical Plans Comparison Chart for an overview of benefits of this plan.
- This Plan provides members referral-free access to UHC's nationwide network of providers.
- Certain in-network preventive care services are reimbursed at 100% before the deductible is met.
- Infertility benefits and employee assistance program benefits are not covered.
- No reimbursement is provided for medical

services, behavioral health services, or prescription drug coverage until the individual or family deductible has been met.

- This Plan contains an in-network family aggregate deductible under both in-network and out-of-network. If you enroll yourself and any dependents in this Plan, you will be subject to an in-network family aggregate deductible of \$2,400 and out-of-network family aggregate deductible of \$4,000.
 - Example One: If you do not incur any eligible expenses during the year, your spouse must meet the entire \$2,400 in-network family deductible before any benefits are paid.
 - Example Two: Even though the in-network individual deductible is \$1,200 and your spouse has incurred \$600 of eligible expenses, you will need to incur an additional \$1,800 of eligible expenses before any benefits will be paid.
- This Plan contains a family aggregate out-of-pocket maximum under both in-network and out-of-network. If you enroll yourself and any dependents in this Plan, you will be subject to an in-network family aggregate out-of-pocket maximum of \$5,000 and an out-of-network family aggregate out-of-pocket maximum of \$10,000.
- Both in- and out-of-network coverage is available although members receive a greater benefit when they receive care from an in-network provider.
- In addition to access to network providers, this Plan provides access to premium networks for transplants and cancer services.

- Coverage is available worldwide for emergency and urgent care. Follow-up care while you are on travel is covered at the in-network level of benefit if you are outside of the United States or not located within 30 miles of an in-network provider within the United States.
- Co-insurance (indicated as a percentage) is the amount the patient pays, after meeting the deductible and is based on either the negotiated fees (in-network) or eligible expenses (out-of-network). Coinsurance amounts apply to the deductible and the out-of-pocket maximums.
- Out-of-network behavioral health benefits do not apply to the out-of-pocket maximums.
- Behavioral health benefits are provided through the United Behavioral Health (UBH) network of providers.

Prescription Drug Information:

- The prescription drug program is administered by Medco.
- Outpatient prescription drug coverage is provided through the UnitedHealthcare retail pharmacy network, not Catalyst Rx.
- Retail prescription drugs can be obtained from national and independent pharmacies, including Albertson's, CVS, Rite Aid, Walgreens, and Wal-Mart pharmacies among others.
- Mail-order prescription drugs can be obtained through Medco.
- Prescription drug payments apply to the annual deductible and out-of-pocket maximums.
- As a new enrollee, you will receive a new combined ID card for medical and prescription drug benefits.

Health Savings Accounts (HSA):

- The advantage of this plan is that it is a HSA-compatible plan allows participants to claim a tax deduction for contributions made to the HSA even if the participant does not itemize deductions on Form 1040. Note: There are some states that impose state taxes.
- The money goes in tax-free, grows tax-free, and can be withdrawn on a tax-free basis if used to pay for certain medical expenses.
- The maximum amount you can put into an HSA in 2008 is either \$2,900 if you enroll as an individual or \$5,800 if you enroll yourself and any dependents.
- Catch-up contributions (up to \$800 for 2008) are allowed for participants age 55 and older.
- YOU decide how you want to invest your funds.
- Unused amounts roll over from year to year and are yours to keep and use.
- If you turn 65, you are eligible to withdraw the funds for non-medical expenses but you will be taxed on the withdrawal.
- If you withdraw the funds before you turn 65 for non-medical expenses, you will incur penalties and be taxed on the withdrawal.
- If you are covered by any other medical coverage (including a flexible savings account), are enrolled in Medicare, and/or are claimed as a tax dependent on another person's tax return, you are NOT eligible to open up an HSA.
- You can either open an HSA with Exante Bank through UnitedHealthcare or you can open an Account on your own. If you open an Account through UHC, Sandia will pay the fees for opening the Account. Any other fees in connection with the Account are paid by you.

- If you enroll in this Plan, you will receive information from UHC regarding opening up an HSA through Exante Bank.
- For more information on this feature, contact UnitedHealthcare at 1-877-835-9855.

Member Resources:

UnitedHealthcare offers the following member resources to aid members in managing their own care and achieving better health.

- Access to a 24-hour nurse advice line (Optum NurseLine) is available at 1-800-563-0416.
- Access to a voluntary disease management program for coronary artery disease, diabetes, congestive heart failure, and asthma.
- Access to health information and convenient self-service tools is available at www.myuhc.com and allows you to:
 - Research a health condition and treatment options to get ready for a discussion with your physician
 - Access wellness topics from Optum NurseLine including Live Nurse Chat 24 hours a day, seven days a week
 - Access a health risk assessment to identify health habits you can improve, learn about healthful lifestyle techniques, and access health improvement resources
 - Access a treatment cost estimator to obtain an estimate of the costs of various procedures in your area
 - Access a hospital comparison tool to compare hospitals in your area on various patient safety and quality measures
 - Make real-time inquiries into the status

and history of your claims

- View eligibility and plan benefit information
- View and print all of your Explanation of Benefits (EOB) online
- Order a new or replacement ID card or print a temporary ID card

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 Medical Plans Comparison Chart and/or attend a Benefits Choices 2008 presentation (a schedule of presentations will be printed in the September 27th edition of the Lab News).



CIGNA PREMIER PREFERRED PROVIDER ORGANIZATION (PPO) PLAN

This medical plan is administered by CIGNA HealthCare. Under this Plan, CIGNA HealthCare provides their Open Access Plus network, which means that members have the freedom of choice to see either an out-of-network (non-contracted) provider or an in-network (CIGNA-contracted) provider.

CIGNA Premier PPO Plan Key Points

Eligibility:

This Plan is available to non-Medicare-primary retirees, survivors, LTD terminees and their eligible non-Medicare-primary Class I and Class II dependents.

Note: If your eligible dependent is Medicare-primary and you enroll in this Plan, you can enroll your dependent in the CIGNA Senior Premier PPO Plan (available nationwide). Class II dependents who are Medicare-primary will be enrolled in the CIGNA Senior Premier PPO Plan.

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.

Plan Changes Effective January 1, 2008: None

Highlights:

- Refer to the retirees' Medical Plans Comparison Chart for an overview of benefits of this plan.
- This Plan gives members referral-free access to CIGNA's nationwide network of

providers, including the Mayo Clinic.

- Infertility and employee assistance program benefits are not covered.
- Both in- and out-of-network coverage is available, but members receive a greater benefit when they choose an in-network provider.
- Coverage is available worldwide for emergency and urgent care. Follow-up care while you are on travel is covered at the in-network level of benefit if you are outside of the United States or not located within 30 miles of an in-network provider within the United States.
- Copayments that you pay to see a physician do not apply to your annual calendar year deductible or your annual calendar year out-of-pocket maximum.
- Co-insurance (indicated as a percentage) is the amount the patient pays, after meeting the deductible, and is based on either the negotiated fees (in-network) or usual and customary charges (out-of-network). Coinsurance amounts apply to the deductible and to the out-of-pocket maximums.
- Out-of-network behavioral health costs do not apply to the out-of-pocket maximum.
- The Lovelace Health System in Albuquerque, NM, which is a contracted network provider under CIGNA HealthCare reorganized two of their medical centers. Hospital operations were moved from the Lovelace Medical Center–Gibson and were combined with the Lovelace Medical Center–Downtown (formerly known as the Albuquerque Regional Medical Center and also as St. Joseph's) in early 2007.

Prescription Drugs:

- The prescription drug program is administered through CIGNA HealthCare.
- Prescription drug copays do not apply to the out-of-pocket maximum.
- Prescription drug copays do not apply to the deductibles.
- The prescription drug program is a three-tiered plan which includes generic, preferred-brand, and non-preferred brand drugs that are available at a co-insurance amount with minimum and maximum copays.
- If the actual cost of the prescription is less than the minimum copayment, you will pay only the actual cost.
- Mail-order prescription drugs can be obtained through the Tel-Drug Mail-Order Drug Program. Mail order offers cost savings and convenience for maintenance medications. To take advantage of the mail order program, you must ask your physician for a 90-day prescription with refills in 90-day increments.
- The maximum supply available from any retail pharmacy is a 30-day supply.

If you and/or your dependent(s) enroll in an individual prescription drug plan (including Medicare Part D), your benefits will be coordinated (according to federal law) with the prescription drug coverage you have with Sandia. Refer to your Part D Creditable Coverage Notice and your medical plan's Summary Plan Description for more information.

Guidelines:

You are responsible for obtaining prior authorization, from CIGNA HealthCare, for certain services out-of-network. Your benefits are reduced by the \$300 penalty for failure to follow prior authorization requirements.

Member Resources:

CIGNA HealthCare offers the following resources to aid members in managing their own care and achieving better health.

- Website at www.mycigna.com for members to obtain a list of network providers, order ID cards, view claim history, and view EOBs. If you are a new CIGNA member, the web site will be available on January 1, 2008 (your effective date). You can create your own user name and password after your effective date.
- Well Aware for Better Health, CIGNA's disease management program, 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 reminders about important screenings and exams.
- CIGNA Healthy Rewards offers discounts to CIGNA members for non-traditional health and wellness programs. Aim for a better and healthier lifestyle by taking advantage of the discounts for any of the following:
 - Weight Watchers,
 - Tobacco cessation services and products,
 - Acupuncture, chiropractic care, and massage therapy, or hearing care and laser vision care.
- To find Healthy Rewards providers simply call 1-800-870-3470 or visit www.cigna.com/healthyrewards
- Nurse advice line available 24 hours a day, seven days a week at 1-800-564-9286.

Finding a Network Provider:

You can obtain a directory of CIGNA network providers at a Benefits Choices 2008 presentation.

You can also search for the most up-to-date network providers available in this Plan through the online provider directory at www.cigna.com or call CIGNA Member Services at 1-800-244-6224.

Additional Information:

For additional information on this Plan, refer to the Medical Plans Comparison Chart and/or attend a Benefits Choices 2008 presentation (a schedule of presentations will be printed in the September 27th edition of the Lab News) or call CIGNA Member Services at 1-800-244-6224 (1-800-CIGNA24).



CIGNA SENIOR PREMIER PREFERRED PROVIDER ORGANIZATION (PPO) PLAN

This medical plan is administered by CIGNA HealthCare. Under this Plan, CIGNA HealthCare provides their Open Access Plus network, which means that members have the freedom of choice to see either an out-of-network (non-contracted) provider or an in-network (CIGNA-contracted) provider.

CIGNA Senior Premier PPO Plan Key Points

Eligibility:

This Plan is available to Medicare-primary retirees, survivors, LTD terminees and their eligible Medicare-primary Class I and Class II dependents.

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

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.

Plan Changes Effective January 1, 2008: None

Highlights:

- Refer to the retirees' Medical Plans Comparison Chart for an overview of benefits of this plan.
- This Plan gives members referral-free access to CIGNA's nationwide network of providers, including Mayo Clinic.
- 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.

- Infertility benefits and employee assistance program benefits are not covered.
- Both in- and out-of-network coverage is available.
- Coverage is available worldwide for emergency and urgent care. Follow-up care while you are on travel is covered at the in-network level of benefit if you are outside of the United States or not located within 30 miles of an in-network provider within the United States.
- Co-insurance (indicated as a percentage) is the amount the patient pays and is based on either the negotiated fees (in-network) or usual and customary charges (out-of-network). Coinsurance amounts apply to the out-of-pocket maximums.
- Out of-network behavioral health costs do not apply to the out-of-pocket maximum.
- 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.
- The Lovelace Health System in Albuquerque, NM, which is a contracted network provider under CIGNA HealthCare, reorganized two of their medical centers. Hospital operations were moved from the Lovelace Medical Center–Gibson and were combined with the Lovelace Medical Center–Downtown (formerly known as the

Albuquerque Regional Medical Center and also as St. Joseph's) in early 2007.

Prescription Drugs:

- The prescription drug program is administered through CIGNA HealthCare.
- Prescription drug copays do not apply to the out-of-pocket maximum.
- Prescription drug copays do not apply to the deductibles.
- The prescription drug program is a three-tiered plan which includes generic, preferred-brand, and non-preferred brand drugs that are available at a co-insurance amount with minimums and maximums copays.
- If the actual cost of the prescription is less than the minimum copayment, you will pay only the actual cost.
- Mail-order prescription drugs can be obtained through the Tel-Drug Mail-Order Drug Program. Mail order offers cost savings and convenience for maintenance medications. To take advantage of the mail-order program, you must ask your doctor for a 90-day prescription with refills in 90-day increments.
- The maximum supply available from any retail pharmacy is a 30-day supply.

If you and/or your dependent(s) enroll in an individual prescription drug plan (including Medicare Part D), your benefits will be coordinated (according to federal law) with the prescription drug coverage you have with Sandia. Refer to your Part D Creditable Coverage Notice and your medical plan's Summary Plan Description for more information.

Guidelines:

Members in this Plan will be considered as having both Medicare Part A and Part B coverage for purposes of coordinating with Medicare and processing claims.

Member Resources:

CIGNA HealthCare offers the following resources to aid members in managing their own care and achieving better health.

- Website at www.mycigna.com for members to obtain a list of network providers, order ID cards, view claim history, and view EOBs. If you are a new CIGNA member, the web site will be available beginning on January 1, 2008 (your effective date). You can create your own user name and password after your effective date.
- Well Aware for Better Health, CIGNA's disease management program, 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 reminders about important screenings and exams.
- CIGNA Healthy Rewards 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 for any of the following:
 - Weight Watchers,
 - Tobacco cessation services and products
 - Acupuncture, chiropractic care, and massage therapy, or hearing care and laser vision care.
- To find Healthy Rewards providers simply call 1-800-870-3470 or visit www.cigna.com/healthyrewards.
- Nurse advice line available 24 hours a day, seven days a week at 1-800-564-9286.

Finding a Network Provider:

You can obtain a directory of CIGNA network providers at a Benefits Choices 2008 presentation. You can also search for the most up-to-date network providers available in this Plan through the online provider directory at www.cigna.com or call CIGNA Member Services at 1-800-244-6224.

Additional Information:

For additional information on this Plan, refer to the Medical Plans Comparison Chart and/or attend a Benefits Choices 2008 presentation (a schedule of presentations will be printed in the September

27th edition of the Lab News) or call CIGNA Member Services at 1-800-244-6224 (1-800-CIGNA24).



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 provider 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.

Notes:

- Class II dependents are not eligible.
- Medicare-primary individuals are not covered under this Plan.
- If you or your covered dependent have end stage renal disease, you are not eligible for this plan.
- If your eligible dependent is Medicare-primary, and you enroll in this Plan, you can enroll your dependent(s) in the CIGNA Senior Premier PPO Plan.

Plan Changes Effective January 1, 2008:
None

Highlights:

- Refer to the retirees' Medical Plans Comparison Chart for an overview of benefits of this plan.
- The CIGNA In-Network Plan has providers available nationwide, including Mayo Clinic.
- Referrals are not required to see any in-network specialist.
- Coverage is provided for services from in-network providers only.

- Emergency and urgent care needs while on travel status are covered when received from out-of-network providers. Any follow-up care must be from an in-network provider.
- Infertility treatment and employee assistance program benefits are not covered under this plan.
- 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.
- The Lovelace Health System in Albuquerque, NM, which is a contracted network provider under CIGNA HealthCare, reorganized two of their medical centers. Hospital operations were moved from the Lovelace Medical Center–Gibson and combined with the Lovelace Medical Center–Downtown (formerly known as the Albuquerque Regional Medical Center and also as St. Joseph's) in early 2007.

Prescription Drugs:

- The prescription drug program is administered through CIGNA HealthCare.
- The prescription drug program is a two-tiered closed formulary that includes generic and brand drugs. Non-preferred brand drugs are not covered under this Plan.
- Prescription drug copays do not apply to the out-of-pocket maximum.
- The maximum supply available from any retail pharmacy is a 30-day supply.
- Mail-order prescription drugs are through the Tel-Drug Mail-Order Program. To take

advantage of the mail-order program, you must ask your doctor for a 90-day prescription with refills in 90-day increments.

If you and/or your dependent(s) enroll in an individual prescription drug plan (including Medicare Part D), your benefits will be coordinated (according to federal law) with the prescription drug coverage you have with Sandia. Refer to your Part D Creditable Coverage Notice and your medical plan's Summary Plan Description for more information.

Guidelines:

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 1 800-244-6224 (1-800-CIGNA24) for details.

Member Resources:

CIGNA HealthCare offers the following resources to aid members in managing their own care and achieving better health.

- Website at www.mycigna.com for members to obtain a list of network providers, order ID cards, view claim history, and view EOBs. If you are a new CIGNA member, the website will be available beginning on January 1, 2008 (your effective date). You can create your own user name and password after your effective date.
- Well Aware for Better Health is CIGNA's disease management program, which 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.

- CIGNA Healthy Rewards 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 for any of the following:
 - o Weight Watchers,
 - o Tobacco cessation services and products, or
 - o Acupuncture, chiropractic care, and massage therapy, or hearing care and laser vision care.
- To find Healthy Rewards providers simply call 1-800-870-3470 or visit www.cigna.com/healthyrewards.
- Nurse advice line available 24 hours a day, seven days a week, at 1-800-564-9286.

Finding a Network Provider:

You can obtain a directory of CIGNA network providers at a Benefits Choices 2008 presentation. You can also search for the most up-to-date network providers available in this Plan through the online provider directory at www.cigna.com or call CIGNA Member Services at 1-800-244-6224.

Additional Information:

For additional information on this Plan, refer to the Medical Plans Comparison Chart and/or attend a Benefits Choices 2008 presentation (a schedule of presentations will be printed in the September 27th edition of the Lab News) or call CIGNA Member Services at 1-800-244-6224 (1-800-CIGNA24).

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. 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, all eligible dependents must be Medicare primary. There is no longer a non-Medicare combination plan linked with the Lovelace Senior Plan. Retirees previously enrolled in a Lovelace Senior Plan/CIGNA non-Medicare combination plan will be grandfathered.
- Class II dependents are not eligible.

Plan Changes Effective January 1, 2008*:

- Outpatient Surgery from \$75 to \$50 copay.
- DME (Oxygen) from \$20 per month to \$0 per month.
- Prescription Drugs (Part D):
 - o Preferred Generic (Retail) from \$10 to \$5 copay.

- o Preferred Brand Name (Retail) from \$20 to \$32 copay.
- o Non-Preferred Brand (Retail) from \$40 to \$62 copay.
- o Specialty Drugs (Retail) \$40 to \$62 copay.
- o Insulin (Novolin or Novolog) from Tier 2 to Tier 1 coverage
- Sleep Studies-Testing:
 - o Daytime study from \$0 to \$50 copay.
 - o Overnight study from \$0 to \$150 copay.
- “Bridges in Medicine” program cancelled.
- Acupuncture \$15 copay, limit 20 visits per calendar year.

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

Highlights:

- Refer to the retirees’ Medical Plans Comparison Chart for an overview of benefits.
- Open Access – No referrals. This feature means that you do not need a referral from your primary care physician (PCP) to see any in-network specialist.
- Unlimited prescription drug coverage is available under this Plan.
- Coverage for emergency and urgent care is available worldwide.
- The Lovelace Health System in Albuquerque, NM, reorganized two of their medical centers. Hospital operations were moved from the Lovelace Medical Center–Gibson and were combined with the Lovelace Medical Center–Downtown (formerly known as the Albuquerque Regional Medical Center and also as St. Joseph’s) in early 2007.

Guidelines:

- 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.
- 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 is 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 nonparticipating hospital for emergency care, you or a family member must call Customer Care within 48 hours (or as soon as reasonably possible).
- Copayments are required at the time of service.

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, 2007, in order to be enrolled in this Plan.

Member Resources:

Lovelace Information Line (1-877-725-2552) 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 (available in certain NM cities including Albuquerque, Rio Rancho, Los Lunas, Belen, and possibly Santa Fe) offers a complimentary basic fitness center membership featuring:

- Easy enrollment at a fitness center located near you;
- Silver Sneakers classes, which are fun, group exercise classes designed to increase strength, flexibility, and energy, taught by certified fitness instructors;
- Senior advisors are available for you to contact for information and personalized, friendly service; and
- Social events where you can make new friends.
- For more information and a list of fitness center locations, visit the web site at www.silversneakers.com.

Selecting a PCP:

You must select a PCP or one will be assigned to you. Obtain a directory at a Benefits Choices 2008 presentation or contact Lovelace Customer Care Center at 505-232-1883 or, outside the Albuquerque area, 1-800-808-7363. Lovelace Customer Care Center is available Monday through Friday, 8:00 a.m. to 5:00 p.m.

Additional Information:

For additional information on this Plan, refer to the Medical Plans Comparison Chart and/or attend a Benefits Choices 2008 presentation (a schedule of presentations will be printed in the September 27th edition of the Lab News). The speech and hearing impaired may call 1-800-288-5605 or 505-232-1810 TTY, Monday through Friday, 8:00 a.m. to 5:00 p.m.

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 Key Points

Eligibility:

This Plan is available to Medicare-primary retirees, survivors, LTD terminees and their eligible Medicare-primary Class I dependents. 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. There is no longer a non-Medicare combination plan linked with the Presbyterian MediCare PPO Plan. Retirees previously enrolled in a Presbyterian MediCare PPO Plan/UHC non-Medicare PPO combination plan will be grandfathered.
- Class II dependents are not eligible.

Plan Changes Effective January 1, 2008*:

In-Network:

- Mental Health/Substance Abuse Office Visit from \$20 to \$25 copay.

- Outpatient Rehab (Cardiac) from \$10 to \$0 copay.
- Dental (Medicare-covered) from \$20 to \$25 copay.
- Hearing Services (Medicare-covered) from \$20 to \$25 copay.
- Hearing Services (Routine) from \$20 to \$25 copay.
- Vision Services (Medicare-covered) from \$20 to \$25 copay.
- Vision Services (Routine) from \$20 to \$25 copay.
- Chiropractic (Routine) not covered.

Out-of-Network:

- Skilled Nursing Facility (days 21 to 100) from \$115 per day to \$125 per day.
- PCP Office Visit from \$25 to \$30 copay.
- Chiropractic (Medicare-covered) from \$35 to \$50 copay.
- Podiatry (Medicare-covered) from \$35 to \$50 copay.
- Urgent Care from \$40 to \$50 copay.
- Outpatient Rehab (non-cardiac) from \$25 to \$30 copay.
- Outpatient Rehab (Cardiac) from \$25 to \$30 copay.
- DME/Prosthetics from \$25 to \$40 copay.
- Hearing Services (Medicare-covered) from \$35 to \$50 copay.
- Hearing Services (Routine) from \$35 to \$50 copay.

Prescription Drugs (Part D):

- Generic (Retail) remains at \$5 copay.
- Preferred Brand Name (Retail) from \$20 to \$35 copay.
- Non-preferred Brand (Retail) from \$45 to \$55 copay.
- Generic (Mail Order) remains at \$10 copay
- Preferred Brand Name (Mail Order) from \$50 to \$87.50 copay.
- Non-preferred Brand (Mail Order) from \$135 to \$165 copay.

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

Highlights:

- Refer to the retirees' Medical Plans Comparison Chart for an overview of benefits.
- Both in- and out-of-network coverage is available, but members receive a greater benefit when they receive care from an in-network provider. You may go to any Medicare-approved practitioner or provider out of network.
- No referrals to specialists are required.
- 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 this 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 1-800-797-5343, Monday through Friday, 8 a.m. to 5 p.m. TTY/TDD users should call 1-888-625-8818.

Guidelines:

- 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.
- 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 are required to select a primary care physician (PCP) even though no referrals to specialists are required.

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, 2007, in order to be enrolled in this Plan.*

Member Resources:

The Presbyterian MediCare PPO Plan offers the following member resources to aid members in managing their own health and achieving better health:

- Access to a 24-hour nurse advice line is available at 1-800-887-9917.
- Access to health and wellness education such as classes and newsletters.
- Access to A.D.A.M., the Presbyterian online medical library at www.phs.org.
- Access to a health risk assessment to identify health habits you can improve, learn about healthful lifestyle techniques, and access health improvement resources.

Selecting a Network Provider:

You can obtain a directory at one of the Benefits Choices 2008 presentations, or you can search for the most up-to-date network providers available in this Plan through the online provider directory at www.phs.org.

Additional Information:

For additional information on this Plan, refer to the Medical Plans Comparison Chart and/or attend a Benefits Choices 2008 presentation (a schedule of presentations will be printed in the September 27th edition of the Lab News) or call the Presbyterian Health Plan at (505) 923-6060 or toll-free at 1-800-347-4766.

KAISER PERMANENTE HEALTH MAINTENANCE ORGANIZATION (HMO) PLAN

The Kaiser Permanente HMO Plan, one of the nation's largest and oldest non-profit health maintenance organizations, is offered to eligible participants in the northern California area. This Plan offers you a choice of nationally recognized providers within the Kaiser network system. You are not limited to receiving care from just one Kaiser facility; you may pick the Plan facility that is most convenient for you. If you are or will be eligible for Medicare-primary coverage, please refer to the Kaiser Permanente Senior Advantage Plan section in this Benefits Choices 2008 booklet for retirees.

Kaiser Permanente HMO 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).

Note: Class II dependents are not eligible.

Plan Changes Effective January 1, 2008: None

Highlights:

- Refer to the Medical Plans Comparison Chart for an overview of benefits of this plan.
- No lifetime maximums.
- May select your own personal physician (and change at your discretion).
- Self-referral to selected specialty departments; others require a referral from your Plan physician.
- One-stop health care—Kaiser Permanente integrates medical offices, specialty offices, laboratory, pharmacy, and optical services at each facility.
- Chiropractic—Your Kaiser Permanente Plan includes 30 visits per year for a \$15-per-visit copayment to an approved American Specialty Network Chiropractor.
- Behavioral Health coverage—see Medical Plan Comparison Chart.
- Accidental Injury to Teeth (AIT) benefit.

Guidelines:

- Outside the Kaiser service area, Kaiser Permanente covers emergency and urgent care only.
- 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.
- Copayments are required at the time of service.

Tips to Reduce Kaiser Medical Plan Costs and Maximize Your Medical Plan Benefits

Urgent Care/Minor Injury:

When you have an urgent health care need or minor injury, consider using Kaiser's Urgent Care and/or Minor Injury Departments rather than the local or Kaiser emergency room. Same day appointments (including weekends) for Urgent Care and Minor Injury can be made through the 24-hour advice line.

Urgent Care and Minor Injury Departments are usually located at your local Kaiser Medical Facility (or a nearby Kaiser facility) and the copay is the same as an office visit – \$15 (an emergency room visit will cost you a \$100 copay). Reserve emergency room visits for true, acute emergencies. You will save time and money with a visit to Urgent Care or Minor Injury.

Prescriptions:

When filling a 100-day supply prescription, remember to use Kaiser's discount mail-order program to reduce your prescription costs. You will receive a 30-day supply in the retail pharmacy for one copay payment, but for many prescriptions, you can receive a 100-day supply through mail-order for two (2) copay payments. If you prefer to use the retail pharmacy exclusively, you will be able to pick up a 100-day supply at the pharmacy for three (3) copay payments. This option will not reduce your costs, but will provide the convenience of fewer visits to the pharmacy.

Member Resources:

Kaiser Permanente offers the following member resources to aid members in managing their own health and achieving better health:

- Information, counseling, and classes on topics ranging from asthma and diabetes management to yoga
- 24-hour Advice Line—As a Kaiser Permanente member, you can obtain health care advice from specially trained registered nurses over the phone, 24 hours a day, seven days a week.
- Health education—Information in the form of videos, reading materials, and free take-home literature is 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.
- Interactive Website—www.kponline.org – make appointments; consult advice nurse or pharmacist, on-line health assessment, health-care glossary, and more.
- Customized online health improvement programs in nutrition, smoking cessation, weight management, and stress reduction
- Access to over 30,000 pages of online health information and a fully illustrated drug encyclopedia
- Discounts on acupuncture, chiropractic services, massage therapy, and preferred membership rates at select fitness clubs
- Weight Watchers discount (average 20%) off regular membership fees
- 10,000 Steps web-based program to help members increase their daily activity level

- Healthyroads.com—through this website members have access to:
 - Healthful lifestyle personalized online programs that focus on weight loss, nutrition, stress reduction, and smoking cessation
 - 25% discounts on regular rates for chiropractic, acupuncture, and massage therapy
 - Preferred membership rates at a variety of fitness clubs nationwide

Additional Information:

For additional information on this Plan, refer to the Medical Plans Comparison Chart and/or attend a Benefits Choices 2008 presentation (a schedule of presentations will be printed in the September 27th edition of the Lab News).



KAISER SENIOR ADVANTAGE PLAN (KPSA)

The Kaiser Permanente Senior Advantage Plan (KPSA), one of the nation's largest and oldest nonprofit health maintenance organizations, is offered to eligible participants in the northern California area. This Plan offers you a choice of nationally recognized providers within the Kaiser network system. You are not limited to receiving care from just one Kaiser facility; you may pick the Plan facility that is most convenient for you.

Kaiser Permanente 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

Note: Class II dependents are not eligible.

Plan Changes Effective January 1, 2008: None

Highlights:

- Refer to the Medical Plans Comparison Chart for an overview of benefits of this plan.
- No lifetime maximums.
- May select your own personal physician

(and change at your discretion).

- Self-referral to selected specialty departments; others require a referral from your Plan physician.
- One-stop health care—Kaiser Permanente integrates medical offices, specialty offices, laboratory, pharmacy, and optical services at each facility.
- Chiropractic—Your Kaiser Permanente Plan includes 30 visits per year for a \$15-per-visit copayment to an approved American Specialty Network Chiropractor.
- Accidental Injury to Teeth (AIT) benefit
- Refractive vision exam for a \$15 copay.
- Optical Services—\$150 allowance toward eyewear every 24 months (KPSA only).
- Behavioral health coverage—see Medical Plans Comparison Chart.

Guidelines:

- 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 Permanente Senior Advantage.
- 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.

- 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.
- Outside the Kaiser service area, Kaiser Permanente covers emergency and urgent care only. 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 days to retain your Senior Advantage coverage.
- Medicare will not pay for any medical care you receive from a non-Kaiser Permanente health care provider unless 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.

Tips to Reduce Kaiser Medical Plan Costs and Maximize Your Medical Plan Benefits

Urgent Care/Minor Injury:

When you have an urgent health care need or minor injury, consider using Kaiser's Urgent Care and/or Minor Injury Departments rather than the local or Kaiser emergency room. Same day appointments (including weekends) for Urgent Care and Minor Injury can be made through the 24-hour advice line. Urgent Care and Minor Injury Departments are usually located at your local Kaiser Medical Facility (or a nearby Kaiser facility) and the copay is the same as an office visit – \$15 (an emergency room visit will cost you a \$100 copay). Reserve emergency room visits for true, acute emergencies. You will save time and money with a visit to Urgent Care or Minor Injury.

Prescriptions:

When filling a 100-day supply prescription, remember to use Kaiser's discount mail-order program to reduce your prescription costs. You will receive a 30-day supply in the retail pharmacy for one copay payment, but for many prescriptions, you can receive a 100-day supply through mail-order for two copay payments. If you prefer to use the retail pharmacy exclusively, you will be able to pick up a 100-day supply at the pharmacy for three copay payments. This option will not reduce your costs but will provide the convenience of fewer visits to the pharmacy.

Member Resources:

Kaiser Permanente offers the following member resources to aid members in managing their own health and achieving better health:

- Information, counseling, and classes on topics ranging from asthma and diabetes management to yoga
- 24-hour Advice Line—As a Kaiser Permanente member, you can obtain health care advice from specially trained registered nurses over the phone, 24 hours a day, seven days a week.
- Health education—Information in the form of videos, reading materials, and free take-home literature is 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.
- Interactive website—www.kponline.org – make appointments; consult advice nurse or pharmacist, on-line health assessment, health-care glossary, and more.
- Customized online health improvement programs in nutrition, smoking cessation, weight management, and stress reduction
- Access to over 30,000 pages of online health information and a fully illustrated drug encyclopedia
- Discounts on acupuncture, chiropractic services, massage therapy, and preferred membership rates at select fitness clubs
- Weight Watchers discount (average 20%) off regular membership fees
- 10,000 Steps web-based program to help members increase their daily activity level
- Healthyroads.com—through this website members have access to:
 - Healthful lifestyle personalized online programs that focus on weight loss, nutrition, stress reduction, and smoking cessation

- 25% discounts on regular rates for chiropractic, acupuncture, and massage therapy
- Preferred membership rates at a variety of fitness clubs nationwide

Additional Information:

For additional information on this Plan, refer to the Medical Plans Comparison Chart and/or attend a Benefits Choices 2008 presentation (a schedule of presentations will be printed in the September 27th edition of the Lab News).

MEDICAL PREMIUM SHARING

MONTHLY PREMIUMS EFFECTIVE JANUARY 1, 2008

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 Table A if you retired with 30 or more years of service.
- Use Table B if you retired with 25 to 29 years of service.
- Use Table C if you retired with 20 to 24 years of service.
- Use Table D if you retired with 15 to 19 years of service.
- Use Table E if you retired with 10 to 14 years of service.

Class II Dependents:

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:

- \$330.48 for the UnitedHealthcare High Deductible Health Plan
- \$389.64 for the UnitedHealthcare Premier PPO Plan
- \$389.64 for the CIGNA Premier PPO Plan

The monthly premium for a Medicare Class II dependent is:

- \$158.00 for the UnitedHealthcare Senior Premier PPO Plan
- \$156.00 for the CIGNA 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	CIGNA Senior Premier PPO	Presbyterian MediCare PPO ¹	Lovelace Senior Plan ¹	Kaiser Permanente Senior Advantage ¹
1	\$23	\$22	\$15	\$6	\$25
2	\$45	\$45	\$30	\$13	\$50

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

Number of Non-Medicare	UHC Premier PPO	UHC High Deductible Health	CIGNA Premier PPO	CIGNA In-Network Plan	Kaiser Permanente HMO
1	\$73	\$61	\$72	\$72	\$61
2	\$145	\$122	\$144	\$144	\$123
3	\$218	\$183	\$216	\$216	\$173

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 Senior Premier PPO	CIGNA Senior Premier PPO	Presbyterian MediCare PPO ^{1*}	Presbyterian MediCare PPO ^{1*}	Lovelace Senior Plan ^{1*}	Lovelace Senior Plan ^{1*}	Kaiser Permanente Senior Advantage ¹
		UHC Premier PPO	UHC High Deductible Health Plan	CIGNA Premier PPO	UHC Premier PPO	UHC High Deductible Health Plan	CIGNA Premier PPO	CIGNA In-Network Plan	Kaiser Permanente HMO
1	1	\$95	\$83	\$94	\$88	\$76	\$78	\$78	\$86
2	1	\$118	\$106	\$117	\$102	\$91	\$85	\$85	\$101
1	2	\$168	\$144	\$167	\$160	\$137	\$151	\$150	\$137

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

*The combination Presbyterian MediCare with UHC Premier or High Deductible Plans and Lovelace Senior with CIGNA Premier or In-Network Plans are no longer available for new enrollment. These rates apply only to previous retirees enrolled in these combination plans.

Medical Premium Sharing

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	CIGNA Senior Premier PPO	Presbyterian MediCare PPO ¹	Lovelace Senior Plan ¹	Kaiser Permanente Senior Advantage ¹
1	\$34	\$33	\$22	\$10	\$38
2	\$68	\$67	\$45	\$19	\$75

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

Number of Non-Medicare	UHC Premier PPO	UHC High Deductible Health Plan	CIGNA Premier PPO	CIGNA In-Network Plan	Kaiser Permanente HMO
1	\$109	\$91	\$108	\$108	\$92
2	\$218	\$183	\$216	\$216	\$184
3	\$327	\$274	\$325	\$324	\$260

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

Mixed Medicare	Non-Medicare	UHC Senior Premier PPO	UHC Senior Premier PPO	CIGNA Senior Premier PPO	Presbyterian MediCare PPO ¹	Presbyterian MediCare PPO ¹	Lovelace Senior Plan ¹	Lovelace Senior Plan ¹	Kaiser Permanente Senior Advantage ¹
		UHC Premier PPO	UHC High Deductible Health Plan	CIGNA Premier PPO	UHC Premier PPO	UHC High Deductible Health Plan	CIGNA Premier PPO	CIGNA In-Network Plan	Kaiser Permanente HMO
1	1	\$143	\$125	\$142	\$131	\$114	\$118	\$118	\$130
2	1	\$176	\$159	\$175	\$154	\$136	\$127	\$127	\$152
1	2	\$252	\$216	\$250	\$240	\$205	\$226	\$226	\$206

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

*The combination Presbyterian MediCare with UHC Premier or High Deductible Plans and Lovelace Senior with CIGNA Premier or In-Network Plans are no longer available for new enrollment. These rates apply only to previous retirees enrolled in these combination plans.

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	CIGNA Senior Premier PPO	Presbyterian MediCare PPO ¹	Lovelace Senior Plan ¹	Kaiser Permanente Senior Advantage ¹
1	\$56	\$56	\$37	\$16	\$63
2	\$113	\$112	\$75	\$32	\$126

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

Number of Non-Medicare	UHC Premier PPO	UHC High Deductible Health Plan	CIGNA Premier PPO	CIGNA In-Network Plan	Kaiser Permanente HMO
1	\$182	\$152	\$180	\$180	\$153
2	\$363	\$305	\$361	\$360	\$307
3	\$545	\$457	\$541	\$540	\$434

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

Mixed Medicare	Non-Medicare	UHC Senior Premier PPO	UHC Senior Premier PPO	CIGNA Senior Premier PPO	Presbyterian MediCare PPO ¹	Presbyterian MediCare PPO ¹	Lovelace Senior Plan ¹	Lovelace Senior Plan ¹	Kaiser Permanente Senior Advantage ¹
		UHC Premier PPO	UHC High Deductible Health Plan	CIGNA Premier PPO	UHC Premier PPO	UHC High Deductible Health Plan	CIGNA Premier PPO	CIGNA In-Network Plan	Kaiser Permanente HMO
1	1	\$238	\$209	\$236	\$229	\$190	\$196	\$196	\$216
2	1	\$294	\$265	\$292	\$256	\$227	\$212	\$212	\$253
1	2	\$419	\$361	\$417	\$400	\$342	\$377	\$376	\$343

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

*The combination Presbyterian MediCare with UHC Premier or High Deductible Plans and Lovelace Senior with CIGNA Premier or In-Network Plans are no longer available for new enrollment. These rates apply only to previous retirees enrolled in these combination plans.

Medical Premium Sharing

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	CIGNA Senior Premier PPO	Presbyterian MediCare PPO ¹	Lovelace Senior Plan ¹	Kaiser Permanente Senior Advantage ¹
1	\$79	\$78	\$52	\$22	\$88
2	\$158	\$156	\$104	\$45	\$176

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

Number of Non-Medicare	UHC Premier PPO	UHC High Deductible Health Plan	CIGNA Premier PPO	CIGNA In-Network Plan	Kaiser Permanente HMO
1	\$254	\$213	\$252	\$252	\$215
2	\$508	\$426	\$505	\$504	\$429
3	\$762	\$639	\$757	\$756	\$607

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

Mixed Medicare	Non-Medicare	UHC Senior Premier PPO	UHC Senior Premier PPO	CIGNA Senior Premier PPO	Presbyterian MediCare PPO ¹	Presbyterian MediCare PPO ¹	Lovelace Senior Plan ¹	Lovelace Senior Plan ¹	Kaiser Permanente Senior Advantage ¹
		UHC Premier PPO	UHC High Deductible Health Plan	CIGNA Premier PPO	UHC Premier PPO	UHC High Deductible Health Plan	CIGNA Premier PPO	CIGNA In-Network Plan	Kaiser Permanente HMO
1	1	\$333	\$292	\$330	\$306	\$265	\$275	\$274	\$303
2	1	\$412	\$371	\$408	\$358	\$317	\$297	\$297	\$354
1	2	\$587	\$505	\$583	\$560	\$478	\$527	\$527	\$481

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

*The combination Presbyterian MediCare with UHC Premier or High Deductible Plans and Lovelace Senior with CIGNA Premier or In-Network Plans are no longer available for new enrollment. These rates apply only to previous retirees enrolled in these combination plans.

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	CIGNA Senior Premier PPO	Presbyterian MediCare PPO ¹	Lovelace Senior Plan ¹	Kaiser Permanente Senior Advantage ¹
1	\$101	\$100	\$67	\$29	\$113
2	\$203	\$201	\$134	\$57	\$226

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

Number of Non-Medicare	UHC Premier PPO	UHC High Deductible Health Plan	CIGNA Premier PPO	CIGNA In-Network Plan	Kaiser Permanente HMO
1	\$327	\$274	\$324	\$324	\$276
2	\$653	\$548	\$649	\$648	\$552
3	\$980	\$822	\$974	\$972	\$781

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

Mixed Medicare	Non-Medicare	UHC Senior Premier PPO	UHC Senior Premier PPO	CIGNA Senior Premier PPO	Presbyterian MediCare PPO ¹	Presbyterian MediCare PPO ¹	Lovelace Senior Plan ^{1*}	Lovelace Senior Plan ^{1*}	Kaiser Permanente Senior Advantage ¹
		UHC Premier PPO	UHC High Deductible Health Plan	CIGNA Premier PPO	UHC Premier PPO	UHC High Deductible Health Plan	CIGNA Premier PPO	CIGNA In-Network Plan	Kaiser Permanente HMO
1	1	\$428	\$375	\$425	\$394	\$341	\$353	\$353	\$389
2	1	\$529	\$477	\$525	\$461	\$408	\$382	\$381	\$455
1	2	\$755	\$649	\$750	\$720	\$615	\$678	\$677	\$618

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

*The combination Presbyterian MediCare with UHC Premier or High Deductible Plans and Lovelace Senior with CIGNA Premier or In-Network Plans are no longer available for new enrollment. These rates apply only to previous retirees enrolled in these combination plans.

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

MONTHLY PREMIUMS EFFECTIVE JANUARY 1, 2008

The LTD terminatee monthly medical premiums vary based on when you became an LTD terminatee. If you became an LTD terminatee 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 terminatee 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 Terminatee before January 1, 2003

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

Number of Medicare	UHC Senior Premier PPO	CIGNA Senior Premier PPO	Presbyterian MediCare PPO	Lovelace Senior Plan	Kaiser Permanente Senior Advantage
1	\$22.50	\$22.30	\$14.90	\$6.37	\$25.16
2	\$45	\$44.60	\$29.80	\$12.74	\$50.31

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

Number of Non-Medicare	UHC Premier PPO	UHC High Deductible Health Plan	CIGNA Premier PPO	CIGNA In-Network Plan	Kaiser Permanente HMO
1	\$72.60	\$60.90	\$72.10	\$72.00	\$61.31
2	\$145.20	\$121.80	\$144.30	\$144.10	\$122.61

Employees who became an LTD Terminatee after December 31, 2002

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

Number of Medicare	UHC Senior Premier PPO	CIGNA Senior Premier PPO	Presbyterian MediCare PPO	Lovelace Senior Plan	Kaiser Permanente Senior Advantage
1	\$78.75	\$78.05	\$52.15	\$22.29	\$88.04
2	\$157.50	\$156.10	\$104.30	\$44.58	\$176.09

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

Number of Non-Medicare	UHC Premier PPO	UHC High Deductible Health Plan	CIGNA Premier PPO	CIGNA In-Network Plan	Kaiser Permanente HMO
1	\$254.10	\$213.15	\$252.35	\$252	\$214.57
2	\$508.20	\$426.30	\$505.05	\$504.35	\$429.14

SURVIVING SPOUSE MEDICAL PLAN PREMIUM SHARING

MONTHLY PREMIUMS EFFECTIVE JANUARY 1, 2008

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 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	CIGNA Senior Premier PPO	Presbyterian MediCare PPO ¹	Lovelace Senior Plan ¹	Kaiser Permanente Senior Advantage ¹
1	\$112.50	\$111.50	\$74.50	\$31.85	\$125.78

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

Number of Non-Medicare	UHC Premier PPO	UHC High Deductible Health Plan	CIGNA Premier PPO	CIGNA In-Network Plan	Kaiser Permanente HMO
1	\$363	\$304.50	\$360.50	\$360	\$306.53
2	\$726	\$609	\$721.50	\$720.50	\$613.06

¹Rates for Presbyterian MediCare PPO Plan, the Lovelace Senior Plan, and the Kaiser Permanente 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.

- If you and your Sandia spouse elect to be covered separately, any eligible dependents may be covered under either spouse (i.e., enroll some dependents under one spouse and others under the other spouse, etc.).
- If you wish to change your coverage for 2008, both Sandians must do so by completing the Open Enrollment Change Form included in this booklet and returning it by midnight, November 9, 2007 (must be postmarked by midnight November 9).
 - The primary covered retiree/employee must enroll his or her spouse and any other dependents by using the Open Enrollment Change Form.

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.

Example:

A Sandia retiree is married to a non-represented Sandia employee in Salary Tier 2 (\$75,001 to \$100,000 base salary). The retiree and employee (and any eligible dependents) may enroll under either employee or retiree and pay the applicable premium and be subject to the applicable deductibles and out-of-pocket maximums of the primary participant.

Note: 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.

ELIGIBILITY GUIDELINES FOR RETIREES

Class I Dependents

Eligibility for Coverage under the UnitedHealthcare (UHC) Premier PPO Plan, Presbyterian MediCare PPO Plan, UHC High Deductible Health Plan, CIGNA Premier PPO Plan, CIGNA In-Network Plan, Lovelace Senior Plan, UHC Senior Premier PPO Plan, CIGNA Senior Premier PPO Plan, and Dental Expense Plan (DEP not available to survivors and 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 child under age 19, including legally adopted children,
- Unmarried child age 19 and over but under age 24 who is “financially dependent” on you, (Financial dependency means that you provide more than 50% of their support for the entire calendar year)
- Unmarried child of any age
 - who is permanently and totally disabled* and is unable to engage in any substantial gainful activity by reason of any 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,

Note: The carrier 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.

- who lives with you, in an institution or in a home that you provide,
- and who is “financially dependent” on you.
- Unmarried child who is recognized as an alternate recipient in a “qualified national medical support order” (QNMSO) enforceable with respect to Sandia’s plan.

Eligibility for coverage under the Kaiser Permanente 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. Please contact Sandia California Benefits Office at 925-294-2254 for more information on enrolling your child as an incapacitated dependent.

Class II Dependents

Note: Class II dependents are eligible to enroll in the UHC Premier PPO, CIGNA Premier PPO, UHC High Deductible Health Plan, UHC Senior Premier PPO Plan, and CIGNA Senior Premier PPO Plans only.

Eligible Class II dependents include your

- Unmarried child or step-child who is not eligible as a Class I dependent,
- Unmarried grandchild,
- Unmarried brother or sister, or
- Parent, step-parent, or grandparent or your spouse's parent, step-parent, or grandparent.

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: Annual verification required.

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 no longer financially dependent
- 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 in the 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 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).

Or if you are currently enrolled in the CIGNA Premier PPO Plan and become Medicare primary, you have the option of enrolling in either the CIGNA Senior Premier PPO Plan or Lovelace Senior 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 High Deductible Health Plan, the UHC Senior Premier PPO Plan or the Presbyterian MediCare PPO Plan, CIGNA Senior Premier PPO Plan, CIGNA In-Network 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 Terminatee option, the LTD terminatee 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 terminatee elects COBRA coverage instead of the LTD Terminatee option, the terminatee cannot elect the LTD option after COBRA coverage terminates. If the terminatee elects the LTD Terminatee 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, 2008.

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

Class II dependent enrollment requires special paperwork processing. To enroll a Class II dependent during Open Enrollment contact Benefits Customer Service at 505-844-HBES (4237) prior to November 9, 2007.

Note: Enrollment of a Class II Dependent outside of Open Enrollment must be consistent with an allowable mid-year coverage change event.

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 mailed to you with this booklet. It must be postmarked by midnight, November 9, 2007.

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 Inspector General.
- Sandia will retroactively terminate dependent coverage, effective the end of the month in which the dependent became ineligible.
- Sandia will refund any applicable monthly premium 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.

2008 OPEN ENROLLMENT APPEALS

The annual Open Enrollment period provides the opportunity to make changes to your benefit choices: Enroll/Disenroll dependents, enroll in or change your Medical or Dental elections. The 2008 Benefit Choices election period began October 20 and ended November 9, 2007 for benefit elections effective January 1, 2008.

Retiree election changes after November 9 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 9, 2007. 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, complete the Open Enrollment Appeals Form on page 49. Requests will be reviewed by the Benefits Manager and/or 3300 Management Team.

A written determination will be sent to you by December 21, 2007.

All requests must be received by December 7, 2007.

OPEN ENROLLMENT APPEALS FORM

Please Print

Date:	Retiree/Survivor Name:	Retiree ID#:	
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Address:

Question 1) Was the reason you failed to make a change due to extenuating circumstance(s)?

No

Stop Here – Your request for enrollment after November 9, 2007 is denied

Yes (go to Question 2)

Question 2) If you failed to make your benefit elections due to extenuating circumstance(s), describe, in detail, the reasons you failed to make your annual elections. Include supporting documentation to show you were on international/remote travel or dealing with a medical emergency for yourself or an immediate family member.

Fax or mail the form postmarked before December 7, 2007.

Sandia National Laboratories
P.O. Box 5800, MS1463
Albuquerque, NM 87185-1463
Attention: Open Enrollment Appeals
or Fax to: 505-844-0662

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 network.

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;
 - XX% 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.

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 on page 55 and it must be received by the Benefits Department by midnight, November 9, 2007. 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, 2008.

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 reenroll in a Sandia-sponsored medical plan.

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 midnight, November 9, 2007.

I, _____, SSN: _____ waive coverage for myself and all dependents in any of Sandia’s medical plans effective January 1, 2008.

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.

Retiree/Survivor/LTD Terminee Signature

Date

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

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CONTACT LIST

Resource	Phone	Web Address
SNL Health Benefits & Employee Services	Customer Service: (NM) (505) 844-HBES (4237) or (800) 417-2634, ext. 844-4237	http://www.oe.sandia.gov
UnitedHealthcare Sandia Group #708576	Customer Service: (877) 835-9855 UHC Nurse Line: (800) 563-0416	http://www.myuhc.com (use SNL for login/password)
Catalyst Rx	Customer Service: (866) 854-8851 (available October 20, 2007)	http://www.catalystrx.com (use SNL for login/password)
CIGNA Sandia Group #3172368	Customer Service and 24-Hour Health Information Line: (800) 244-6224	http://www.cigna.com
Delta Dental Sandia Group #9550	Customer Service: (800) 524-0149	www.consumertoolkit.com
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: (800) 464-4000	http://www.kp.org