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Your Health. Take Charge.



BENEFITS CHOICES 2010 OPEN ENROLLMENT NEWSLETTER - October 2009

Visit <http://hbe.sandia.gov> for up-to-date information

Take Charge. It's Decision Time – Benefits Choices 2010 Open Enrollment

It's time again to make your benefit election decisions for the upcoming calendar year. The web enrollment system will be available from October 19 through November 4.

Benefit elections will not be accepted after 5:00 pm (MST), November 4. All benefit elections take effect January 1, 2010. Employees can locate the web enrollment tool through HR Self-Service on the internal Tech Web page. It is your responsibility to thoroughly review your benefit enrollments for 2010 through the web-page "PeopleSoft Open Enrollment" between October 19 through November 4. This will be your only opportunity to make changes without a qualifying event.

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

What's changing for me in 2010?

- CIGNA Premier PPO Plan is being eliminated as a plan choice
- UHC and CIGNA Plans have design changes (e.g., copay increases)
- Specialty drugs must be purchased through Catalyst Rx Drug Management Program for UHC and CIGNA members and specialty drugs will be limited to a 30 day supply at the retail coinsurance/copay level of benefits
- New Dental Care Plan (with premium share), which replaces the current Dental Expense/Deluxe plans
- Important change to Student Intern Medical coverage
- Employee medical premium-sharing will increase to 20% overall and will move from a single tier to four tier salary premium share structure
- Special Long-Term Disability Plus enrollment bypassing evidence of insurability requirement this year only!
- Class I and Class II eligibility policy for health care plans has been modified
- Federal legislation known as "Michelle's Law" will be implemented - Unmarried step children age 19 to 23 can take a medically necessary leave of absence and continue coverage under the Sandia plan for up to 12 months (unless the child's eligibility would end earlier for another reason)
- Health Care Flexible Spending Account (formerly known as a Health Care Reimbursement Spending Account) maximum allowed is increasing

MTC Employee

Benefit Fairs for 2010

Albuquerque

- **October 21 10:00 am – 2:00 pm**
Steve Schiff Auditorium Bldg. 825
- **October 28 10:00 am - 2:00 pm**
Steve Schiff Auditorium Bldg. 825

Presentation Agenda for All Benefit Fairs

Benefit Choices Overview
10:00 am – 10:30 am **October 28 only**

Flexible Spending Accounts - PayFlex Systems
1:00 pm - 2:00 pm **each day**

Do you need to use the Web Based Open Enrollment Application?

	Take Action	No Action
Medical Coverage	<ul style="list-style-type: none"> To enroll in a new medical plan if you are currently in the CIGNA Premier PPO Plan To enroll if not currently enrolled To change your current medical plan To add or disenroll a dependent To waive coverage 	<ul style="list-style-type: none"> No change if you are currently enrolled in the UHC Premier PPO, UHC Standard PPO or CIGNA In-network plan
Dental Coverage	<ul style="list-style-type: none"> To waive coverage if you do not want the Dental Care Plan in 2010 To enroll if not currently enrolled To add or disenroll a dependent 	<ul style="list-style-type: none"> To be enrolled in the Dental Care Plan if you are currently enrolled in the Dental Expense/Deluxe plan
Vision Coverage	<ul style="list-style-type: none"> To enroll if not currently enrolled To add or disenroll a dependent To waive coverage 	<ul style="list-style-type: none"> No change in your current vision coverage
Flexible Spending Accounts (FSA)	<ul style="list-style-type: none"> To enroll in a Health Care FSA for 2010 (even if you participated in 2009) To enroll in a Day Care FSA for 2010 (even if you participated in 2009) 	<ul style="list-style-type: none"> To not be enrolled for 2010
Vacation Buy Plan	<ul style="list-style-type: none"> To enroll for 2010 (even if you participated in 2009) 	<ul style="list-style-type: none"> To not be enrolled for 2010
Voluntary Group Accident Insurance (VGA)	<ul style="list-style-type: none"> To enroll, disenroll or change coverage 	<ul style="list-style-type: none"> No change in your Voluntary Group Accident Insurance Coverage
Long-Term Disability Plus <small>(One Time Only Opportunity To Increase Coverage Without Evidence Of Insurability)</small>	<ul style="list-style-type: none"> To increase or decrease current coverage (additional 10% or 20% coverage) 	<ul style="list-style-type: none"> No change in your Long-Term Disability Plan coverage

What Class I and Class II Eligibility Policy has been changed?

Health Plan Eligibility Changes

Class I Dependents

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

Note: Unmarried step children age 19 to 23 can take a medically necessary leave of absence and continue coverage under the Sandia plan for up to 12 months (unless the child's eligibility would end earlier for another reason)

Class II Dependents

No new Class II Dependents can be enrolled in any of the Sandia medical plans. All eligible Class II dependents currently enrolled under a medical plan may continue coverage.

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

Enrolling Eligible Dependents

You can add eligible dependents to your medical, dental, and/or vision plan when you first enroll in the plan or during the annual Open Enrollment period. You may be

able to enroll dependents during the plan year ONLY when you experience a qualified life event, such as marriage, birth or loss of other coverage, that allows enrollment in the plan. Please refer to the Sandia Health Benefits Plan for Employees Summary Plan Description for qualifying mid-year election change events. The change must be made within 31 calendar days of the event (60 days for birth and adoption) or you will have to wait until the next annual Open Enrollment period to add your dependent.

Important: Although your dependent may be eligible for and enrolled in the medical, dental, and/or vision plan, it is important that you determine if your dependent qualifies as a qualifying child or qualifying relative under Internal Revenue Service Publication 502 to determine whether imputed income applies to the premiums. If your dependent does not meet the criteria as a qualifying child or qualifying

[> more on page 4](#)

2010 Class I and Class II Eligibility Policy

Verifying your dependent meets the current criteria is important!

Class I Dependents

Eligibility for coverage under the Sandia health care plans (medical, dental, vision).

Dependent Category	Eligibility	Must meet all applicable requirements
Spouse	To any age	<ul style="list-style-type: none"> Not legally separated or divorced from you Note: An annulment also makes the spouse ineligible for coverage.
Your natural child, child placed for adoption or adopted, or a child for whom you have legal guardianship	To age 24	<ul style="list-style-type: none"> Unmarried
Your Stepchild	To age 19	<ul style="list-style-type: none"> Unmarried Lives with you at least 50% of the calendar year
	19 to age 24 ¹	<ul style="list-style-type: none"> Unmarried Full-time student
Your natural child, legally adopted child, or child for whom you have legal guardianship who is recognized as an alternate recipient under a Qualified Medical Child Support Order	To age 24	<ul style="list-style-type: none"> Unmarried If a court decree requires the primary covered member to provide coverage
Your over age disabled child	Age 24 or older	<ul style="list-style-type: none"> Unmarried Permanently and totally disabled according to the medical claims administrator² Unable to engage in any substantial gainful activity by reason of medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than one year according to the claims administrator Who lives with you, in an institution or in a home that you provide Who is financially dependent on you

¹Unmarried step children age 19 to 23 who are post secondary school students and who must take a leave of absence due to a serious illness or injury, can continue coverage under medical, dental, and/or vision plan for up to 12 months (unless the child's eligibility would end earlier for another reason).

²If only enrolled in both dental and vision, permanently and totally disabled status will be determined by the dental claims administrator.

Class II Dependents

No additional Class II Dependents can be enrolled in any of the Sandia medical plans. To continue to qualify for medical coverage, a Class II dependent must:

- be unmarried (unless they are your or your spouse's parent, step-parent, or grandparent).
- be financially dependent on you.
- have a total income, from all sources, of less than \$15,000 per calendar year other than the support you provide.
- have lived in your home, or one provided by you in the United States, for the most recent six months.

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

Health Plan Eligibility Changes (cont.)

relative under the tax code, you are required to contact the Benefits Department to determine whether any imputed income may apply for that nonqualified dependent. Please refer to the Sandia Health Benefits Plan for Employees Summary Plan Description, Section 3 Eligibility for more information.

Disenrolling Ineligible Dependents

You can disenroll dependents during the Open Enrollment period. During the year, if your dependent becomes ineligible for any

reason, you must disenroll your ineligible dependent within 31 calendar days of the dependent becoming ineligible.

Consequences of Not Disenrolling an Ineligible Dependent

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

- your ineligible dependent's coverage will be retroactively terminated, effective the

end of the month in which the dependent became ineligible

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

2010 Medical Plans at a Glance

Employees currently in the CIGNA Premier PPO Plan must select a new plan during Open Enrollment to have medical coverage in 2010.

	UnitedHealthcare Premier PPO	UnitedHealthcare Standard PPO	CIGNA In-Network
Type of Plan	Preferred Provider Organization (PPO)	Preferred Provider Organization (PPO)	Exclusive Provider Organization (HMO Look-Alike)
Provider Network in New Mexico	Presbyterian UNMH Independent Providers	Presbyterian UNMH Independent Providers	Lovelace Health System UNMH Independent Providers
In/Out Network Coverage	Both	Both	In-Network Only
Referrals to Specialist Required	No	No	No
Plan Design	Primarily Coinsurance	Primarily Coinsurance	Primarily Copays
	Out of Network Deductible	In and Out of Network Deductible	No deductible
Prescription Drug Program Administrator	Catalyst Rx	Catalyst Rx	Catalyst Rx

Important Change for Student Interns!

Summer student interns will no longer be eligible for medical plan coverage. Year round student interns will be limited to the UHC Standard PPO Plan medical coverage. Student Interns currently in the UHC Premier PPO, CIGNA Premier PPO, or CIGNA In-Network, must select the UHC Standard PPO Plan during Open Enrollment to have medical coverage in calendar year 2010.

Medical Plan Premiums

Employee Medical Premium Sharing - Effective January 1, 2010

MTC employees will move from a single tier to four tier salary premium share structure. Salary Tier 1 up to \$50,000, and Tier 2 from \$50,001 to \$80,000, as of January 1, 2010. Although we have moved to a 4 tier option, MTC employees will primarily fall into tier 1.

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

Medical program and family coverage tier	Tier 1*	Tier 2**
UnitedHealthcare Standard PPO⁺		
Employee only	\$42	\$60
Employee and child(ren)	\$76	\$108
Employee and spouse	\$86	\$123
Employee, spouse, and child(ren)	\$122	\$174
UnitedHealthcare Premier PPO		
Employee only	\$49	\$70
Employee and child(ren)	\$88	\$126
Employee and spouse	\$101	\$144
Employee, spouse, and child(ren)	\$142	\$203
CIGNA In-Network		
Employee only	\$54	\$76
Employee and child(ren)	\$96	\$136
Employee and spouse	\$111	\$156
Employee, spouse, and child(ren)	\$156	\$220

⁺ Year Round Student Interns are only eligible for the UHC Standard PPO and the monthly premium share falls under Tier 1.

* Tier 1: Base salary of up to \$50,000 as of January 1, 2010

** Tier 2: Base salary of \$50,001 to \$80,000 as of January 1, 2010

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:

\$255.50 for the UnitedHealthcare Standard PPO Plan
 \$298.90 for the UnitedHealthcare Premier PPO Plan

The monthly premium for a Medicare Class II dependent is:

\$214.90 for the UnitedHealthcare Senior Premier PPO Plan

Long-Term Disability Plus special enrollment

Effective January 1, 2010, the benefit under the employee Sickness Absence Plan (short-term disability) is being reduced from 2080 hours to 1040 hours at full pay, and the Disability Retirement benefit currently under the Retirement Income Plan will no longer be a benefit for employees. Because of this change, employees have an opportunity to enroll in the employee paid Long-Term Disability Plus Plan, without evidence of insurability, during the 2010 Open Enrollment period (this year only).

Why should I consider purchasing additional Long-Term Disability (LTD) insurance?

LTD Plus insurance provides additional salary protection if you become totally and permanently disabled and are unable to perform the duties of your job or any other job suitable to your education, training and experience. LTD takes over after you have exhausted your Sickness Absence Plan (short-term disability) benefit. For more information see the Long-Term Disability Plus Summary Plan Description.

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



2010 Medical Plan Changes >> Effective January 1, 2010

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

Employees currently enrolled in this plan should carefully evaluate the medical plan options offered. Employees must select another medical plan option during Open Enrollment to have coverage in Calendar Year 2010.

CIGNA In-Network Plan Changes:

- CIGNA members' prescription drug benefits will mirror the UHC plans prescription drug benefit. It is important to take time to evaluate and understand how the prescription coinsurance structure will impact the drugs you purchase. To find out if your prescription drug is preferred or not, call Catalyst Rx at (866) 854-8851.
- Office Visit – Primary Care Physician from \$15 to \$20 copay
- Office Visit – Specialist from \$25 to \$30 copay
- Allergy Testing from \$25 to \$30 copay
- Emergency Room from \$100 per visit to \$125 per visit
- Outpatient Surgery from \$100 to \$125 copay
- Chiropractic, Acupuncture, Speech, Physical, and Occupational Therapy from \$15 to \$20 copay
- Inpatient Admission (Medical and Behavioral Health) - from \$200 per day up to \$500 maximum to a single \$400 copay per admission
- Ambulance from \$50 to \$75 copay
- Hypnotherapy and biofeedback are no longer covered

CIGNA In-Network Pharmacy Benefit Changes Retail (maximum 30-day supply)

- **Generic** – from \$10 copay to 20% of retail network price with \$6 minimum and \$12 maximum
- **Preferred Brand** – from \$30 copay to 30% of retail network price with \$25 minimum and \$40 maximum

- **Non Preferred Brand** – from not a covered benefit to 40% of retail network price with a \$40 minimum and \$60 maximum

Mail Order (maximum 90-day supply)

- **Generic** – from \$20 copay to 20% of mail order price with \$12 minimum and \$24 maximum
- **Preferred Brand** – from \$60 copay to 30% of mail order price with \$50 minimum and \$80 maximum
- **Non Preferred Brand** – from not a covered benefit to 40% of mail order price with \$80 minimum and \$120 maximum

Other

- New Mandatory Specialty Drug Program (for more information see article this page)

UnitedHealthCare (UHC) Premier PPO Changes:

- Office Visit Copay – Primary Care Physician from \$15 to \$20 copay
- Office Visit Copay – Specialist from \$25 to \$35 copay
- Allergy Treatment from \$25 copay to 15% of negotiated fees
- Chiropractic – from combined Acupuncture/Chiropractic benefit to a separate calendar year \$1,000 maximum combined in- and out-of-network
- Acupuncture – from combined Acupuncture/Chiropractic benefit to a separate calendar year \$1,000 maximum combined in- and out-of-network
- Hypnotherapy and biofeedback are no longer covered

UnitedHealthCare (UHC) Standard PPO Changes:

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

- Acupuncture – from combined Acupuncture/Chiropractic benefit to a separate calendar year \$500 maximum combined in- and out-of-network

- Hypnotherapy and biofeedback are no longer covered

UnitedHealthCare (UHC) Premier and Standard Pharmacy Benefit Changes:

- Mail Order Generic – from \$18 copay to 20% of mail order price with \$12 minimum and \$24 maximum
- Mail Order Preferred Brand – from \$65 copay to 30% of mail order price with \$50 minimum and \$80 maximum
- Mail Order Non Preferred Brand – from \$100 copay to 40% of mail order price with \$80 minimum and \$120 maximum
- New Mandatory Specialty Drug Program (for more information see article below)

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

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

Mandatory Specialty Drug Program Overview

In order to receive coverage for specialty medications, these drugs must be purchased through the Catalyst Rx Specialty Drug Management Program. These drugs are delivered via mail order through the Specialty Pharmacy (Walgreens). All specialty prescriptions will be limited to a 30 day supply and will be subject to the retail coinsurance/copay structure (e.g., 30% coinsurance with a \$25 minimum copay and \$40 maximum copay for a preferred brand drug). If you are currently taking a specialty medication, you must contact Walgreens Specialty Care 866-823-2712 to request transition assistance to prevent any disruption in your medication therapy. To find out whether a drug you are taking is considered a specialty medication, contact Walgreens Specialty Care.

Dental Care Program (DCP) Changes effective January 1, 2010 – New Plan

Employees will have a new Dental Care Program, which replaces the current Dental Expense/Deluxe plans. The Dental Care Program will be a coinsurance plan replacing the schedule type benefit plans offered today. All regular employees and limited term employees are eligible to participate in DCP (except student interns).

Delta Dental will issue identification cards under the primary subscriber with a unique identification number. The ID card only lists the primary covered member and the alternate ID number is just one number that all family members use. One card will be issued for single and two cards per family, additional ID cards can be ordered through

the Delta Dental toolkits website at www.toolkitsonline.com

Program Highlights

Eligible expenses will result in a \$50 individual annual deductible (with a \$150 family maximum), with the exception of preventive and orthodontic services. The annual maximum for all expenses is \$1,500 per person. The lifetime orthodontic maximum is \$1,800 per person. Sealants for children under 14 will be covered under the preventive benefit. Employees will pay a monthly premium share, on a pre-tax basis.

There are three options when you access care under the DCP. You can access a dentist

upon point of service through the Delta Dental PPO network, the Delta Dental Premier network, or out-of-network. Reimbursement, depending upon which access point you use, is shown in the chart below:

Dental Care Program Monthly Premiums for 2010

Employee only	\$8
Employee plus one	\$16
Employee plus two	\$22

For more information see the Dental Care Program Summary.

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

Vision Care Program (VCP)

Changes effective January 1, 2010 – None

Have annual optical needs? Save some money by using the Sandia VCP

The Vision Care Program is the company-paid vision program. The Vision Care Program is a basic benefit designed to encourage regular eye examinations, assist with the expenses for needed eyeglass frames and corrective lenses, and help offset the cost of additional eyewear purchases through a network provider. Currently, the Vision Care Program is administered by Davis Vision. All regular employees and limited term employees are eligible to participate in VCP (except student interns).

For more information see the Vision Care Program Summary.

Flexible Spending Accounts

The Flexible Spending Accounts are authorized under federal tax law and were established by Sandia for employees' benefit. The Plan allows you the option to set aside tax-free dollars from your paychecks to pay for eligible health care and day care expenses.

All regular employees and limited term employees are eligible to participate in this plan (except student interns). **This program requires re-enrollment every year.**

Health Care Flexible Spending Account (HCFSA)

Changes Effective January 1, 2010

Important: HCFSA maximum increased from \$4,000 to \$5,000.

HCFSA Highlights

The HCFSA is limited to a minimum annual amount of \$100 up to a maximum amount of \$5,000.

- Eligible expenses include annual deductible amounts, copayments, coinsurance, and eligible out-of-pocket for medical, dental, and vision expenses not fully covered by these plans.
- Eligible over-the-counter medications, such as allergy, antacids, cold medications and pain relievers are eligible for Flexible Spending Account reimbursement.

Flexible Spending Account (cont.)

- These expenses must be for you or dependents you claim as exemptions on your tax return.
- Eligible expenses do not include the cost of foods, including reduced-calorie diet foods.
- Your full election amount is available to you for eligible expenses at any time during the plan year.
- You can be reimbursed only up to the amount currently in your DCFSFA at any time during the plan year.
- To be eligible for this account if you are married, both you and your spouse must be working full or part-time or your spouse must attend school full time.
- Eligible expenses do not include amounts you pay for food, clothing, entertainment, transportation, overnight camp, or education.

Day Care Flexible Spending Account (DCFSFA)

Changes Effective January 1, 2010 – None

DCFSFA Highlights

- The DCFSFA is limited to a minimum annual amount of \$100 up to a possible maximum amount of \$5,000 (based upon spouse's annual income and your tax filing status).
- Eligible expenses include costs for a child care provider or qualified child care center for your children under age 13.
- Also eligible are costs for a home care provider or a qualified care center for your spouse or other qualified dependents who are physically or mentally incapable of self-

care and whom you claim as an exemption on your tax return.

- Deductions will be taken evenly from 26 pay periods in 2010.
- Contributions to the FSA Plan do not affect what you put into the Sandia Savings Plans.
- Keep ALL of your FSA documentation with your tax records (incl. debit card receipts).

Debit Cards

A Debit Card can be used as an alternative method to pay and process your eligible out-of-pocket health care costs.

For more detailed plan options and benefits, refer to the Flexible Spending Account Summary Plan Description.

Flexible Spending Account Savings Calculator

The FSA Savings Calculator will help you itemize unreimbursed health and dependent care expense and estimate your annual increase in spendable income if you should choose to participate in the Flexible Spending Account plan. Visit Payflex website at <https://www.payflex.com/mypayflex/savingsCalculator.htm> to access the tool and other valuable FSA educational materials.

Vacation Buy Plan **Need work/life balance? – Buy some extra time in 2010!**

Sandia's Vacation Buy Plan (VBP) allows participants to purchase vacation on a pre-tax basis. By participating in VBP, employees can spread out the financial impact of purchasing additional paid time off over the course of a calendar year. Contributions are deducted evenly from your biweekly paychecks throughout the calendar year, beginning with the second paycheck of the year. Unused purchased vacation will not be carried into the next calendar year and will be sold back in the last paycheck in December at the same rate as purchased.

All regular employees and limited term employees are eligible to participate in VBP (except student interns). Eligible employees may purchase between 8 and 44 hours, deducted evenly from biweekly paychecks throughout the calendar year.

This program requires re-enrollment every year.

Guidelines

- A minimum of 8 hours to a maximum of 44 hours of vacation may be purchased on a pre-tax basis.
- The cost for these vacation hours is automatically deducted from your paycheck throughout the calendar year before taxes are taken out.
- When you take purchased vacation hours, you will be paid at the same rate as purchased and you will be taxed on this amount.
- The cost of each vacation hour you purchase is determined by dividing your full-time annual base pay as of the beginning of the calendar year by 2,080.
- Carryover, accrued/posted, and convertible vacation must be used before using purchased vacation.

- When taking purchased vacation, enter project/task numbers 10000.310 and the number of hours taken on your timecard.
- Purchased vacation hours must be used by the last timecard that is paid in the current calendar year.

Tip for Managing Your Bought Vacation

Consider using your total bought vacation early in the calendar year when your vacation balance is low. Employees that hold on to the bought vacation may run into charging barriers because they have accrued too much vacation into their balance. Remember, in order for your bought vacation to be charged, you must physically place the bought vacation code (A310) on your timecard.

For more detailed plan options and benefits, refer to the Vacation Buy Plan Summary Plan Description

Voluntary Group Accident Plan (VGA) offered by The Hartford

This accident insurance may be purchased by employees for personal or family coverage. Participation in the program is completely voluntary for employees. Employees may purchase this plan or change coverage only during Open Enrollment for coverage beginning on January 1, 2010. However, enrolled participants may disenroll at any time during the year.

Take no action if you are satisfied with your current coverage. Your current coverage will continue through 2010 unless you cancel or change coverage.

All regular employees and limited term employees are eligible to participate in VGA (except student interns).

Coverage Amounts and Plans

Coverage is available from \$10,000 to \$300,000 in increments of \$5,000. Total coverage in Plan I-A, Plan I-B, and Plan II must not exceed \$300,000. Employees may select any combination of:

- **Plan I-A:** Employee-Only Coverage.
- **Plan I-B:** Family Plan may include employee, spouse, and children. Specific rules apply to coverage of dependents. The election amount chosen will result in a benefit amount as follows: spouse only, 50% of election amount; spouse and children, 40% and 10% each; children only, 15% each.

- **Plan II:** Employee-Only Common Carrier insurance covers the employee for accidents aboard public transportation.

Voluntary Group Accident Insurance (VGA) Premiums

The minimum Principal Sum for Plan I or II is \$10,000. You may choose one of the Plans or any combination of I-A, I-B, and/or II, not to exceed a maximum combined benefit of \$300,000. The cost for this coverage is based on the Principal Sum elected, as shown in the table below.

Monthly Cost for Coverage Effective January 1, 2010			
Principal Sum	Plan I-A Employee Only 24-Hour Coverage	Plan I-B Family Plan 24-Hour Coverage	Plan II Employee Only Common Carrier
\$10,000	\$.27	\$.43	\$.05
25,000	.68	1.08	.13
50,000	1.35	2.15	.25
75,000	2.03	3.23	.38
100,000	2.70	4.30	.50
150,000	4.05	6.45	.75
200,000	5.40	8.60	1.00
250,000	6.75	10.75	1.25
300,000	8.10	12.90	1.50

Premium Payment

Payroll deductions will begin in December 2009 for coverage effective January 1, 2010.

This coverage is offered to Sandia employees by The Hartford. Sandia's roles, with respect to the program, are to permit the insurer to publicize the program to employees, to collect premiums through payroll deductions, and to remit them to the insurer.

All matters, such as a change of beneficiary or a claim for benefits, are to be taken up directly with the Program Administrator:

**The Hartford
Group Benefits Division, Customer Service
P. O. Box 2999
Hartford, CT 06104-2999**

Or Call 800-523-2233 (provide policy number ADD-S06402 and policyholder [Sandia])

For more detailed plan options and benefits, refer to the Hartford Voluntary Group Accident Benefit Plan document http://www.sandia.gov/benefits/spd/pdfs/vgaspd_21_web.pdf or call the number above.



Medicare Part D Eligible Individuals – Notice of Creditable Coverage

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

Women’s Health and Cancer Rights Act of 1998

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

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

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

Health Insurance Portability and Accountability Act (HIPAA) Special Enrollment Periods

Under the special enrollment provisions of HIPAA, you may be eligible, in certain situations, to enroll in a Sandia medical or vision Program during the year.

- If you declined enrollment in a Sandia medical or vision Program for yourself or your eligible dependents (including your spouse) because of other group or individual medical or vision coverage, you may be able to enroll yourself and your eligible dependents in a Sandia medical or vision Program during the year. This special enrollment may be available if, during the year, you or your eligible dependent(s) lost coverage under a non-Sandia-sponsored individual or group medical or vision plan (regardless of whether the person who lost coverage is eligible for or elected COBRA continuation coverage). For this purpose, a loss of coverage may include:
 - Coverage ended due to loss of eligibility;
 - Employer contributions to the plan stopped;
 - The plan was terminated;
 - COBRA coverage ended; or
 - The lifetime maximum for medical benefits was exceeded under the non-Sandia-sponsored medical or vision plan.

You must request special enrollment in a Sandia medical or vision Program within 31 calendar days of the loss of coverage, otherwise, you will need to wait until the open enrollment period. Coverage will be effective as of the date of loss of coverage or upon receipt of enrollment paperwork, whichever is later.

- If you gain a new dependent during the year as a result of marriage, birth, adoption or placement for adoption, you may enroll that dependent, as well as yourself and any other eligible dependents, in the medical or vision Program.

You must request special enrollment in a Sandia medical or vision program within 31 calendar days of the event, otherwise, you will need to wait until the open enrollment period. If the event is birth, adoption, or placement for adoption, coverage will be retroactive to the date of the event. If the event is marriage, coverage will be effective as of the date of the event or upon receipt of enrollment paperwork, whichever is later.

- Effective April 1, 2009, if you or your eligible dependent is eligible for Sandia medical or vision coverage, but not enrolled, you may request enrollment before the next annual open enrollment period under the following circumstances:
 1. You and/or your dependent(s) become eligible for a premium assistance subsidy under Medicaid or the Children’s Health Insurance Program (CHIP) with respect to coverage under a Sandia medical or vision Program, if you request coverage under a Sandia medical or vision Program no later than 60 days after the date you or your dependent(s) is determined to be eligible for such assistance.
 2. Coverage under Medicaid or CHIP for you and/or your dependent(s) is terminated as a result of loss of eligibility for such coverage, and you request coverage under a Sandia medical or vision Program no later than 60 days after the date of termination of such coverage.

To request special enrollment or obtain more information, contact HBE Customer Service at 505-844-HBES (4237).

Note: Special enrollment rights allow you to either enroll in your current medical Program or enroll in any medical Program for which you and your dependents are eligible.



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

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

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

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Your Health. Take Charge.

Sandia Corporation's benefit plans are maintained at the discretion of Sandia. They do not create a contract of employment. The plans may be suspended, modified, or discontinued at any time and without prior notice, subject to applicable collective bargaining agreements and except as otherwise provided by applicable law.

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